LEGISLATIVE ASSEMBLY FOR THE AUSTRALIAN CAPITAL TERRITORY

STANDING COMMITTEE ON HEALTH, COMMUNITY AND SOCIAL SERVICES

(Reference: Access to primary healthcare services)

Members:

MR S DOSZPOT (The Chair)
MS J BURCH (The Deputy Chair)
MS A BRESNAN

TRANSCRIPT OF EVIDENCE

CANBERRA

WEDNESDAY, 5 AUGUST 2009

Secretary to the committee:
Ms G Concannon (Ph: 6205 0129)

By authority of the Legislative Assembly for the Australian Capital Territory

WITNESSES

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Amended 21 January 2009

The committee met at 9.20 am.

FIELD, MS JULIE, Acting Health Services Commissioner, Human Rights Commission

THE CHAIR: Good morning. I would like to welcome you all—you in particular, Ms Field—to this public hearing of the Standing Committee on Health, Community and Social Services, which is inquiring into access to primary health care services in the ACT. Are you aware of the privilege statement that is provided?

Ms Field: Yes, I have read that.

THE CHAIR: Have you read that and are you comfortable with that?

Ms Field: Thank you.

THE CHAIR: I would like to do just a couple of housekeeping matters. If you have a telephone, can you ensure that it is on silent mode or turned off. When you first address any of the committee, could you just give your name and title and who you represent. Being the only one giving us evidence in this inquiry today, I am sure you do not have to do this on each separate occasion. Before we start asking you any questions that we may have, would you like to make an opening statement?

Ms Field: Yes, I would, thank you. As you know my name is Julie Field and I am the Acting Health Services Commissioner and the Disability and Community Services Commissioner. I am one of three commissioners who make up the Human Rights Commission. The other commissioners are Dr Helen Watchirs, who is the Human Rights and Discrimination Commissioner, and Mr Alasdair Roy, who is the Children and Young People Commissioner.

In my role as Health Services Commissioner I take complaints about health services and services for older people. I also take complaints about access to health records under the Health Records (Privacy and Access) Act. In addition, my office receives inquiries, many of which can be dealt with by providing advice without the need to go through a formal complaint process. We encourage people to talk to providers about concerns they have with the providers before coming to us, although in some cases this just is not appropriate or possible.

When I receive a complaint I am required to tell the person complained about about the complaint. My staff consider the complaint and we usually ask for a response from the person complained about. If my staff believe that there is a likelihood that that complaint will be resolved, the complainant and the service provider may undergo conciliation through the commission.

Post conciliation, there may be an agreement which can be registered and enforced as a court order. A conciliation agreement may involve a payment to a complainant, an apology or other action. If a complaint raises more serious systemic issues, we will undertake an investigation and we may make recommendations. It is an offence if a person to whom a recommendation is made does not let me know what action they are taking in relation to it in a stated time frame.

The commission has a number of powers, including a name and shame power, but we have not yet used the name and shame power. Last year I received about 170 complaints about health services and services to older people, and approximately 70 complaints were copied to me by various health profession boards; so I also considered those. Of the 170 complaints, nearly 20 per cent related to access to health records.

Broadly, the access to health records complaints I receive can be separated into three groups. People are concerned about the amount they are charged for access to health records, people want their original records, and people want access and have not received it or not received it in a timely way.

Usually with the first group, who are people concerned about the amount they are charged for access to health records, those complaints get dealt with fairly quickly. Either they are being charged the right amount or they are not. Usually it is a confusion and they tend to go away quite quickly.

People who want their original records are in a much more difficult position. To the best of my knowledge there has not been a court case deciding, ultimately, about who has ownership of health records. The Health Records (Privacy and Access) Act gives a right of access rather than a right of ownership. Original records can be supplied to meet the requirements of the health records act but a copy will satisfy those requirements in most cases.

At the moment, by far the largest number of complaints I receive in relation to health records relates to lack of access in a timely way. With recent closures and transfers of practices, access to health records and the process of notifying about transfers and closures have been attracting a lot of attention. It is interesting to note that although the media has picked up on unsuccessful closures with little or no notice, there have been a small number of closures and transfers that have been affected and managed in compliance with the legislation in the last six months.

There are a number of issues in relation to health records when a practice closes or relocates. One issue is that in group practices, as in marriage, people do not always think about what they want to happen when the relationship breaks down. That can lead to tensions and patients can get stuck in the middle of that. When a practice closes or relocates there may be a large number of patients requiring access to their records within a very short period of time. In that case it can be difficult to meet the deadlines in the Health Records (Privacy and Access) Act, even with the best will in the world.

In some cases it has not been clear to providers that the Health Records (Privacy and Access) Act in fact applies to them. Perhaps that is why they have not been able to meet the requirements as well because they did not go into the process realising what they would have to comply with.

I understand that there are moves at a national level to standardise privacy laws, including in relation to health records. I do not believe this will affect the operation of the Health Records (Privacy and Access) Act but I think it is important that we in the

ACT do not lose the express right to access health records in a stated time frame.

In my role as Disability and Community Services Commissioner I take complaints about services provided to people with disability. I would like to talk briefly about people with a disability and about health services. In the ACT 45,200 people, making up 14.2 per cent of the population, report having a disability. While many people with disability function without needing medical support, others do not. There are many obstacles faced by people with disability when seeking access to medical services.

One obstacle is diagnostic overshadowing, which is where a person's symptoms are attributed to the person's disability and no further testing or investigation is done. This can lead to people with a disability not receiving the medical care that they need for quite common complaints. One of the best methods of addressing this is to have consistent care from a GP, particularly one conversant with the particular disability. This means that the current GP shortage and closures tend to impact disproportionately on people with a disability.

Another obstacle for people with a disability is that a small injury that would not impact greatly on someone without a disability can have a significant impact on them. For example, I refer to a person with a limited ability as to their weight. A person with cerebral palsy who suffers an injury to a limb may need extra attention more quickly to avoid losing a limited ability to weight bear. Once again, continuity and care are really what we need in cases like this.

I would like to briefly mention health services for older people. There have been primary health services in the ACT that have made home visits. Home visits can be essential for older people who cannot otherwise access health care. Services of this kind have declined and it is probably a symptom of GP shortages. Also, because the home visits take up more time, they are not as economically viable. As the population ages this is becoming a more pressing need. It is also a significant problem for people with a disability and when a single person is older and has a disability. In this situation, there is an increased likelihood of that. The complexity and subsequent need multiply.

A final issue with older people and GP access: older people generally cannot get into nursing homes unless they have a GP. So if they do not have a GP that also prevents them from getting into nursing homes. I have drawn my comments from complaints received by my office; so I hope that has been a helpful introduction. I am sorry I did not make a formal submission.

THE CHAIR: Thank you. There are a number of issues that you have raised that are obviously very much of interest to us. We will be asking questions regarding most of them, I imagine, based on our previous discussions. You mention that you have had about 170 complaints in relation health issues overall. What happens when these complaints come in and you have examined them? What action are you able to take?

Ms Field: Generally, what we do is to have an initial consideration. We are required to send the complaint out to the person complained about so that they know from a natural justice perspective that a complaint has been made. They will respond. Generally, we then send that back to the person who made the complaint and get a

response from them. We can then either investigate further or we can go to conciliation. Sometimes in a case where there is a live issue—say, somebody has had an accident; they have not had the appropriate care; they desperately need a service provided—we can short-circuit the process and ring somebody and say, "There is this person; they are not receiving their care."

There are bodies located in hospitals and sometimes service providers whom we can ring and ask, "Can you please do something about this now?" Then we go through the complex process. For an investigation, we can get health records and we can see whether people have done things in an appropriate way. If there is a clinical issue, we can then take those records out and show them to an independent person, an independent expert, and see if the appropriate behaviour was—

THE CHAIR: So you have the authority to actually take the records and pass them to the correct area where they are required?

Ms Field: We cannot do that, no. No, we cannot act as a conduit. We can only use them for the purpose of investigation.

THE CHAIR: Then what happens to the records?

Ms Field: They stay with us. We do not pass them on.

THE CHAIR: So when the person that those records related to has a GP or whoever it has to go, do you then pass the records on or do you still keep the records?

Ms Field: In relation to a health records access question, what would happen?

THE CHAIR: Yes.

Ms Field: Yes, sorry. In relation to a health records access question, we generally do not ask for the records ourselves. What we do is we talk to the record keeper about providing the records. We find it particularly effective, if we have got a case of clinical need, to alert them to that. If someone has got a large volume of requests for access, we can highlight to providers that the particular people have clinical needs and there is a health issue involved. They will usually escalate providing those records to families.

MR HANSON: Can I ask a follow up to that, if that is all right?

THE CHAIR: Yes.

MR HANSON: Let us say that you have found someone that has done something inappropriate; perhaps there is negligence or a record has not been released where it should have been. You get expert opinion that says that it was negligence and so on. What do you then do? Do you have powers to fine or to prosecute? You mentioned name and shame. Do you refer it then to another statutory body who then can prosecute? What is the final step in the process if you cannot sort it out through mediation or other means?

Ms Field: If there is a standards issue involved—if a health professional has not provided the appropriate standard of care—we go through a particular health professional body and we have a joint consideration. We can refer them to a health panel if there is a health issue in relation to the actual GP or health provider. A professional standards panel is used if it is a purely standards issue. From that, it can go on to ACAT where the person can be deregistered.

MR HANSON: Okay, so it is a registration issue?

Ms Field: It is a registration issue.

MR HANSON: What about if it is less about an individual doctor? What if it is more about a systemic issue with ACT Health, a service provider or someone else?

Ms Field: Systemic issues generally are dealt with by making recommendations at the close of the case. What I would do in the closing letter, and I would have already run this past the area because they need to have a look at it just from a natural justice perspective, is say that this is the situation, these are the problems and I make the following recommendations; so put systems in place to deal with such and such and so and so. I can make recommendations about apologies and things like that.

MR HANSON: What is the follow up on those recommendations? Do you say to ACT Health, for example, you should do X. What is the follow-up to make sure that they do X or they do not do X?

Ms Field: They have to get back to me within either 40 days or three weeks to tell me what they are doing in relation to the recommendations. Then we also have a six-month follow-up. If we had a problem, particularly with a government department that was not coming to the party on that sort of thing, we would probably name them in the annual report and, if we can, ask the Attorney to table the report in the Assembly.

MS BRESNAN: I want to follow up on that. You said that you can pass on some complaints to health professionals or boards if that is warranted. With the new accreditation registration processes that are coming in, that is going to have some impact on professional boards as they now exist. Do you think that is going to affect the process at all that you can currently follow?

Ms Field: I think it is. The commission is looking at performing the public interest assessor role. Whereas at the moment we have a joint consideration and it is really two equal parties—it is the health profession board and the commission—the public interest assessor does have a role and they can make a more serious outcome the one that gets followed. Then there can be an investigation and it comes back and the public interest assessor has another role.

I guess what I see is that, at the moment as Health Services Commissioner, I can look at standards issues and try and get a result or try to get a better result for everybody. That really gives the consumer a result that they can live with, whereas health boards tend to look at things from a standards perspective. Being a national board, because there will be a national board, I am not sure whether they will take a more public

interest approach. I think we will probably still have some power. If there is to be public interest we will still have the power to investigate but generally the board investigation will take precedence.

MS PORTER: My question is around the health records. Do you get many complaints about incomplete records and what do you do in these cases?

Ms Field: Basically, if people are giving incomplete records they are not providing records in accordance with the act. We have had some cases recently which were inadvertent. I think it was just people not understanding how the computer process worked. Basically, we go back to them and let them know. There are no actual penalties in relation to health records, privacy and access. There is only a power to complain and that is my power under the Human Rights Commission Act. So I can make recommendations and things like that but there is no power to fine or anything like that.

MS BRESNAN: You mentioned in your opening remarks people with a disability when they often go to see someone having the disability treated rather than the symptoms they are presenting with and how not having access to a GP impacts on that. I appreciate that you may not be able to tell us this, but have you received complaints along that line when that has happened to people when they have gone to see someone?

Ms Field: Yes. It tends to be cases where people have been treated for a long time and very basic things have been missed because people are saying that this is just another form of deterioration of the disability. Yes, there have been cases when things like bladder infections have been missed, things like that. Reactions to medication have also been missed because GPs and health professionals can attribute that to the disability.

MS BRESNAN: Has that been impacted by the fact that they have not been able to go and see a person who, I guess, knows their history?

Ms Field: It is certainly a factor. It can be missed by local GPs as well. It is just that there is more chance of picking up changes in behaviour and what is normal for them in relation to the disability with consistency.

MR HANSON: What is the resourcing of the health commissioner? Is it just you?

Ms Field: No.

MR HANSON: Have you got someone to help you?

Ms Field: Yes, I have a staff. We have about four or five investigators. I have maybe four investigators, not all of whom work full time. I have got an intake officer, and she is the one who deals with all of the increase that comes in. She gives people a lot of information so that, if they can deal with something on their own, they do not have to make a formal complaint. She familiarises them with the process. She is quite good at telling people what we can and cannot do so that they do not waste time if it is not an issue we can help them with. And I have a conciliator who works three days a

week.

MR HANSON: Are you adequately resourced?

Ms Field: Because we are a small organisation we are quite susceptible to fluctuations. If we have people go off on maternity leave or if we have people down with flu, you tend to notice that impact. Yes, more assistance would always be good.

MR HANSON: If you had to give "yes" or "no" as an answer and I asked that question again, would you be able to? Is it too hard to break it down that simply? You could be more effective if you had more resources, is that what—

Ms Field: Yes, I could be more.

MR HANSON: You could be more effective. So you are limited in your effectiveness with the current level of resources?

Ms Field: Yes. I have adequate resources for when everything is going well and everything happens in a timely fashion, but for things like large problems that happen that produce a lot of complaints, that can be quite problematic to deal with.

MR HANSON: Have you requested additional resources from the government at this stage to deal with those sorts of contingencies?

Ms Field: I think that the commission—I guess everybody is aware that there are budget restrictions at the moment and things are being cut back, so—

MR HANSON: Have you been cut back?

Ms Field: Well, we have to find a saving.

MR HANSON: A dividend.

Ms Field: Yes, an efficiency dividend.

MR HANSON: That is impacting on you as well, is it?

Ms Field: Yes.

MR HANSON: What is that in terms of percentage, do you know?

Ms Field: We are being asked to fund one per cent.

MR HANSON: So your sense is that you are very tight in what you can do, that you have no flexibility, that if larger cases come along, you have problems dealing with them, and you are being asked to make a difficult efficiency dividend. Is that a reasonably accurate picture of where you are at?

Ms Field: I think so, yes.

MR HANSON: Have you put the case to the minister to say that in order to do your job, you should be exempt from the dividend or that you indeed may need additional resourcing?

Ms Field: I believe we are in the process of doing that.

MR HANSON: So you are putting in a submission, are you?

Ms Field: Yes.

MR HANSON: All right, thanks.

THE CHAIR: Thank you, Mr Hanson. Ms Porter, I understand you have a question. Due to time constraints, this will be the last question at this point.

MS PORTER: With regard to what you were saying about people with disabilities or any patient requiring continuity of care, I wondered if you wanted to make or could make any comment about the suggestion from government about changes to the scope of practice for nurses and allied health workers in that they may have a role to prescribe. I refer also to the fact that we would have nurse-led clinics?

Ms Field: I think that would be very helpful. I would encourage really anything that gets more care out to more people. Yes, I think that is—I would support that.

MS PORTER: So you do not see any issues with it? You see it is as a positive?

Ms Field: I think so, yes.

THE CHAIR: Ms Field, thank you for your opening statement, which really gave us quite an insight into the workings of your area. No doubt there will be other questions. We did not really get past the first lot of questions that we wanted to ask, so there may be some further questions going to you in a written format. If we could get some responses on that, we would appreciate that. If there is anything further that comes to your mind about some of the issues that you think this committee, this inquiry, needs to know more about, we would be very happy to accept information from you in written format as well.

We thank you very much for joining us here this morning. There will be a full transcript given to you of what took place here this morning. Thank you very much.

Ms Field: Thank you very much.

LOWEN, MR PHIL, Chief Executive Officer, ACT Division of General Practice
THOMSON, DR JENNY, Principal Medical Adviser, ACT Division of General Practice

THE CHAIR: Good morning, Mr Lowen and Dr Thomson. I would like to welcome you this morning to this public hearing of the Standing Committee on Health, Community and Social Services, which is inquiring into access to primary healthcare services in the ACT. You have a privilege statement before you. Have you seen that privilege statement before? If not, could you just read it? Do you understand the implications in the privilege statement?

Mr Lowen: Yes.

Dr Thomson: Yes.

THE CHAIR: Thank you. Just one small matter of housekeeping: if you do have a phone, could you make sure it is on silent or turned off? Before we start asking questions, would you like to make an opening statement?

Mr Lowen: The Division of General Practice in the ACT welcomes the opportunity to make a submission this morning. The ACT Division of General Practice and its members see no compelling argument for radical change in models of care, but rather the elimination of inefficiencies in operations, significant nurse improvements, electronic share-care healthcare records, effective communications, investment in business, flow improvements to build capacity for effective cooperation between existing players combined with a structured and sustained approach by all governments to educating and retaining the next generation of GPs.

The key issues conveyed to us from our members are that there is a workforce shortage of GPs and practice nurses. Like all small business, a significant amount of patient care time in the current workforce is taken up with bureaucracy, complexity of service coordination and compliance issues. There is a need to improve on poor communications between providers involved in patient care and there is a complexity of navigating the patient journey through ACT public sector services, agencies, not-for-profit providers and support groups. All this adds significantly to the burden of care on general practice.

There are major problems providing appropriate medical support to aged-care facility residents, and support is needed for an increased teaching role for the increased numbers of medical students, interns, GP registrars and other health professionals who are requiring clinical placement in general practice settings. We recognise clearly though that not all the levers are in the hands of ACT Health or this jurisdiction. Rather, the funding models and red tape are firmly within the jurisdiction of the federal government. Nonetheless, there are still opportunities for improvement at the local level.

We are certainly concerned that there needs to be more study of the workforce locally and mapping of future needs across the ACT. We recognise that the recent GP task force has not really had access to the detailed Medicare data on distribution of workforce and distribution of services that is needed for thorough mapping.

On workforce, our main recommendations are that there should be a literature search and further research into attraction and retention factors for career choice and general practice, and for funding of a professional ACT-specific survey of attraction and retention factors not dissimilar to approaches taken in surveying nurse attraction and retention factors in recent years. We really need to understand the workforce and the motivators, particularly with intergenerational change.

I continue to stand by our estimates that we are 60 GPs short in the ACT to adequately meet short and projected short-term workforce needs. We certainly call for more detailed modelling of the workforce. We believe there is merit in expanding the role and the resources of the GP workforce working group and for the support role to extend to practice nurses and nurse practitioners on workforce issues.

We call for close cooperation between ACT Health, the division and other stakeholders to review nursing scope for practice issues in primary healthcare and, in particular, the aged-care setting. Any new centres created by ACT Health must be fully integrated with general practice and other primary healthcare providers in the area. As I said before, we need to really map through Medicare data where the actual full-time workforce is distributed.

We welcome the budget initiatives from the recent ACT budget and thank the Assembly, but we do call for the early implementation of those budget initiatives. I will touch on the main categories.

On education, we believe there needs to be a continued demonstration of support for the advantages of the integrated vertical GP stream model that is currently in place here. In the ACT, things are working very well in an integrated fashion and this can be built on. Initiatives should be considered for student nurse placements in general practice and the aged-care setting as well.

There needs to be adequate GP registrar training positions for the ACT. That is essential for equitable distribution of current places. We are part of a much wider training region—coast, city, country—extending from the coast right the way through to the South Australian border. There is a strong emphasis on distribution into rural areas. Sometimes the ACT is not getting enough places and opportunities to facilitate our own needs.

International medical graduate recruitment throughout the ACT would be enhanced through the designation of the whole-of-ACT as a district of workforce shortage. We fail to understand why the commonwealth resists this, given that Darwin and Hobart are entirely regarded as outer-metropolitan for these purposes.

On the GP development fund, we certainly welcome the initiative. It is a small amount of money, but we need to make sure that it goes a long way towards assisting capacity building within general practice. We are looking at categories such as equipment, capital works, IT infrastructure and software upgrades to collaborate and build connectivity between players in the sector. We are looking at incentives that assist with medical and nursing staff recruitment, staff development opportunities, local support for disadvantaged patient groups, education support and infrastructure

for students, interns and registrars, and alternative models of care and uptake of practice accreditation.

We are also suggesting that part of the money be set aside as an innovation pool to support innovations that could be replicated across the sector—collaborative support and interest groups to support disadvantaged patient groups such as the Indigenous population, mental health, homelessness, refugees, GP self-care initiatives, and access into the training and orientation for international medical graduates who are new to Canberra. These are the important components, I think, of the development fund.

We particularly welcome the $91 million over four years for e-health. E-health is the enabling technology for a lot of the changes. In particular, we see the rollout of the discharge summaries and the incremental transformation from sending blocks of information or text to usable atomised data that can be imported into GP desktops and/or the share-care record as being an important part of future investment. The rollout of e-referrals past the current pilot stage, including standardisation of intake and referral procedures and evaluated process design with public agencies and general practice, would add considerable value and remove many of the red-tape hurdles.

A recognition of the GP desktop systems, though, is vitally important. It is also important that from the public perspective the ACT does not just focus on the hub-and-spoke model, but understands that care is a connectivity like a web. We have to be communicating as much between GPs, specialists and other members of our allied health teams as we do with public agencies. So we would not like to see all of the money just going into the hospitals.

The early implementation of ACT shared electronic health records for residents in Canberra would obtain maximum benefits. We think that early implementation for target groups such as maternal mothers and babies, diabetes and chronic disease sufferers and aged-care residents would reap immediate returns to the community and solve a lot of our current problems. We believe we currently have the support of the ACT health department in heading in that direction of introducing something that draws people in who have the need rather than being seen as some sort of imposition or scary Australia card-type record.

The introduction of electronic medication charting in public hospitals and aged-care facilities is something GPs are really looking for as well. We really want to be able to see the transfer of current medications to a recorded share-care record or direct access to that record in order for GPs to provide better care. That will certainly reduce falls, complications and the demand on the ED department as well. So there is a dividend back to the government in investing in that area.

We would like to see the inclusion of a minimum data set within the electronic record. That would allow for transition of care between providers on patients changing doctors, seeing other than their normal doctor, practice closures and transfers. Had we had such a central record, then a lot of the issues that came up during the recent Belconnen consolidation would not have been present, because there would have been simple transition of care into a summary record, and the summary record could have been electronically warehoused, which saves all those issues then of whether the record has moved interstate and where the hard copy is.

There are a couple of things that are already in place. X-ray films and digital CDs are now in place, but we believe this needs to go further so that there is access to the actual picture archive system online. When we introduce new technology, we should not simply substitute an electronic means of doing something for what was a manual means, but look at how to optimise and change business flow to actually enhance the healthcare outcomes.

On aged care, the division formed an aged-care forum. About 50 or 60 people I think attended our first night. They then broke into a voluntary group—an aged-care forum working group that has been working on aged-care issues. It is now in its third meeting. It has also made some recommendations recently on the minimum requirements they see to the GP task force for infrastructure support and aged-care support, in particular building on the initiative that government has given by funding of what we are still calling the in-hours locum service, but for which the GPs, the aged-care providers and the RACFs are saying need to be much more widely considered than simply focusing on locum support issues.

THE CHAIR: Mr Lowen, can I interrupt briefly? We do have a time constraint, so I ask you to consider that.

Mr Lowen: I will just move to funding models. I think it is important that you do appreciate, and it is something that is out of your control to an extent, that the GP funding model is driven by Medicare funding. That has its major limitations, particularly in the areas that are seen as the biggest areas of potential crisis in care, like aged care and chronic disease.

While Medicare is a very market-driven service and something that GPs generally support as being fee for service, it does not pay for and recognise non-contact time. That non-contact time is quite substantial in areas such as aged care, where there will be calls about a patient fall or medication changes, and you are not actually seeing the patient. The same is the case for chronic disease management.

There is also a concern that with Medicare funding there is a tendency to invent another item number every time a new idea comes up. These item numbers are often applied in different ways. You can have quite a different model for asthma care than you have for diabetes care based around different item numbers, their complexity and their financial incentives. It is a very difficult space to navigate.

There are also a number of practice incentive payments and service incentive payments to practices and doctors who perform certain kinds of care but these are very complicated as well and they do not always derive the right outcomes that you are looking for. Certainly, many of these are tied in their level of support to whether you are in an inner or outer metropolitan area of Canberra, whether you are in a rurality area and the score of the area in which you are working—and that means that inner Canberra, where much of our need is, often does not get access to the adequate resourcing.

I will comment very quickly on records access and legislation, noting that the commissioner was here just before us. We do not believe there should be any

sanctions. We think that most of the issues were around poor communication and access to information on what was required, a lack of clarity and incompleteness in the legislation and even difficulty in finding things. For example, the fact sheets were hidden in parts of the ACT website the GPs would not necessarily go looking for, such as the consumer section, not the GP section.

We think that the three-week notice period is generally adequate. We think that it is sensible that records can be transferred by a patient nominating a transfer within the three-week period, whereas the legislation technically does not really allow for that. We think that, as we have said before, with national standards and emerging issues around electronic care records nationally, we need to wait patiently around some of the national legislation changes before making substantial changes to local legislation. But e-health is the pathway and the solution to most of the problems.

Finally, in navigating care, one of the biggest problems in the ACT is the huge amount of red tape. The red tape is a burden to practice anyway. It seems to be about $15,000 per year per practitioner. Where it affects what we do here in this jurisdiction is around how we interface with the public system. There are more than 26 different provider directories and indexes in the ACT. There is no consolidated navigation framework or easy web-based point we can go to. Links are often poorly coordinated, they do not look the same in the field, and GPs probably do not even have a high awareness of the full range of services that are available and tend to use segments of services they become familiar with because of the incompleteness of provider information and accessibility to understanding what those services do. So we would certainly like to see some high priority given to provider directory development in the ACT as well. Thank you.

THE CHAIR: Thank you, Mr Lowen. I do apologise about pushing on with things; we have a finite time frame. I have a quick question before I hand over to my colleagues. We have had submissions from people in specialist medical services areas who feel that they are impacted on from a regional point of view. I certainly think that hospitals fall into that category as well. But from the GP's point of view, is there an impact from regional demand for services on our GPs or are we pretty well contained just to the ACT area?

Dr Thomson: One thing that comes to mind immediately is that I currently just started working at Winnunga Nimmityjah Aboriginal Health Service, and that is an example of a service that does provide services beyond the ACT to some Indigenous people regionally. That immediately comes to mind.

Certainly, I also recently just stopped my practice in Dickson and we did have people coming in from just outside our northern border, quite commonly, into our practice in Dickson. So I would imagine that we do have some people moving across borders because people work in the ACT and therefore use GP services in the ACT but I am not sure we have a really good handle on what that—

Mr Lowen: No, that again is where Medicare sits on the data. They can map by where a patient's postcode is against where they are utilising. That is why I was saying that there is still inadequate information to make a proper judgement without access to that Medicare data.

Our membership certainly spans the border; so we have members in our division who are also members of southern general division—from Bungendore, Queanbeyan, even out to Cooma and Yass in some cases. Certainly, on the boundary around Queanbeyan, it is pretty amorphous. People move across it. The pandemic flu showed us that most Queanbeyan doctors saw ACT as the primary point of referral. They follow ACT guidelines rather than New South Wales guidelines, because of the level of integration of services across that borderline.

MS BRESNAN: You mentioned that the workforce is the key issue. You have just mentioned again the GP task force not having access to key Medicare data to be able to map. Has that been because the task force itself has requested the data and not been given it or is it because the ACT government has requested it, figuring they have not been given—

Mr Lowen: I cannot really comment on that. We did suggest to the task force that they approach the Medicare statistics unit for the information. We appreciate that Medicare may want to roll the information up to levels to prevent identification. They may want to roll it up into districts—Belconnen, Woden, Weston and so on—so you could at least get mapping at that level. I would not have thought that would have been an impediment. Mapping it down to individual practice distributions may be something that would have to be negotiated with the commonwealth.

MS BRESNAN: So you are not really sure what the situation is?

Mr Lowen: I don't know what it is currently. The maps that came out in the interim report have some deficiencies. There is a map that has a distribution of GPs. I will give an example of the problem based on the experience of one of my board members.

In full-time equivalence, her practice is about 1.1 but on her door she lists eight or nine GPs. This is because there are quite a few sessional GPs, part-timers and retirees. So is she a seven or eight-doctor practice or she is a one doctor practice? I think that is what we have to really find out. What is the mapping? In my database, I would only attach a doctor to the database based on their nominated primary practice location. So if I do a mapping exercise I will have a completely different map than the actual full-time work load distribution or what ACT Health records.

MS BRESNAM: There has been that limited mapping which has already been done. So you are not sure if there is actually going to be a more detailed mapping exercise as part of the whole GP task force process.

Mr Lowen: We are trying to do our own. We have a GP census going out next month through which we are trying to get a better handle on the workforce issues. One of the big issues here is that there is a lot of confusion about what a GP is and how many there are. I have 498 members who are self-identifying GPs or medical practitioners but I know there are only 425 who have provider numbers in the workforce. Of that 425, we think there are only around 383 full-time equivalents.

So there are a lot of GPs doing other work, and recent studies of the subgroup of those sessional workers has indicated that, apart from a few who are making decisions

around child-rearing years or pre-retirement years, the majority of those GPs did have other work.

They work in TGA, Veterans' Affairs, Defence, government at all levels; so it is a very interesting town with quite a different mix. It is a mix that actually can attract GPs as well. We are seeing the younger GPs, in particular, who seem to like that variety of doing a bit of teaching, doing a bit of work with Indigenous people or refugees and not going to work and facing the high volume workloads. Others, on the other hand, do. They like just to walk into a job, let someone else manage the practice, deal with the workload, go home at night and not have to worry about the patients.

MR HANSON: Firstly, well done on your submission, I thought that was very comprehensive and obviously you have got a key role to play in this whole business.

It seems that a lot of the discussion out there is about the shortage of GPs and the impact on patients. However, I know there is also an impact on GPs. I speak to a number of GPs who are under a lot of pressure and a lot of stress. I guess that that is a real concern as well because, if that is a workforce that is unhappy, that is not going to help with retention and it is also probably not going to help with patient outcomes. Can you provide a view on that for us?

Mr Lowen: We just did a recent study with our GPs. It was our own review of the division. One of the things we asked, almost as a byproduct to the questioning, related to GPs' satisfaction with their life, their contribution to the community, their health and things of that type.

Quite surprisingly, GPs have a very positive life view with a very high level of satisfaction. That was certainly higher than the national average. On the area of health, they were fractionally poorer in terms of their self-opinions around health. We found that male GPs are particularly poor, like most males are generally, in terms of accessing other GPs for support or for self-care.

There are areas that we are certainly working on with the mental health advisory committee to look at GP self-care issues, but there are certainly stresses. I think that workforce shortage does not really rate much more than about three or four on the scale of many of the different surveys. What is No 1 on the scale always seems to be the red tape: "I cannot care for my patients because I am having to navigate the ridiculous complexity of Medicare item numbers. I have to spend 10 to 20 minutes trying to find another service provider because there are in incomplete directories or I do not have current information on all the new doctors that have been appointed in clinics in ACT Health or if I do, I do not know the times." There is a lot of work for the reception and support staff in practice at the moment. Jenny is probably in a better position to comment as a real GP.

Dr Thomson: That is a major issue. Now we are in a position where for every session I spend with patients—that is sort of a four-hour block of time—I would have another hour of just paperwork and non-time with the patient. That has been increasing over the years. I have been a GP now for 35 years or so; so it just seems to be increasing exponentially. That is coming from, I suppose, federal systems.

The Medicare system has become extremely complex. We have got lots of new item numbers. They all have requirements, different formats and templates we have to use. Here in the local system, again, we have different referral forms for different agencies. They all have their own way of wanting us to do business with them, and that creates additional loads for us, as does the complexity of actually navigating people through the system and being the advocate for that navigation. It is complex for the patients as much as for us as GPs.

MS PORTER: I would just like to go back to your comments about reviewing the scope of practice. I want to ask a question about suggested changes in the way that practice nurses and allied health workers might work. The government is suggesting, for instance, that we might have nurses referring and prescribing. We might have walk-in centres that are staffed entirely by nurses. I was wondering whether both of you could make some comments about that. Also, could you tell us what your membership think about it?

Mr Lowen: The membership is very mixed, obviously. It is diverse, ranging from small business to employees and people working in multiple parts of government agencies. I think there is a consensus though that there is not an opposition to expanding the roles of scope of practice. However, those scopes of practice need to be appropriately evidence-based and well defined.

We certainly would resist any expansion of things like prescribing in the absence of a share-care record where the primary carer, coordinator or the GP can see what is going on. Otherwise, we are just setting ourselves up for harm if you have somebody prescribing something without knowing the full range of conditions and the GP is not aware of what is happening. So there are dangers there. We are more than happy to work with the government on scope of practice.

On nurse-led walk-in clinics, we have made a separate submission to the government on that. We see no compelling overseas evidence in the research to suggest it has any positive impact on general practice. It does, however, have a significant impact potentially on levels four and five ED presentations. On that basis we have supported and been actively involved with ACT Health in the establishment of the nurse-led walk-in clinic at Canberra Hospital.

MS PORTER: Are you saying that you see the e-health as part of the key to being able to work in this way with nurse practitioners?

Mr Lowen: I think it is an essential prerequisite. You cannot really have a team working in a coordinated fashion unless you have a means of integrating the data; so I think e-health is absolutely crucial for the capacity of the change process of the future.

MS PORTER: Thank you. Dr Thomson, did you have any comment you wanted to make?

Dr Thomson: Yes. I think one of the concerns would be establishing another silo of care. That has tended to be what has happened over the years. We have had good ideas and we have wanted to improve access for patients to care and develop another service that is not interrelated or interconnected with other primary care services. I

refer particularly to the GP services because that is the place where more people go more often. So we do need to have that appropriate linkage when we establish any new service. We are really keen that that issue be looked at.

MS PORTER: So integration and e-health are the two key components?

Dr Thomson: Yes, and determining scopes of practice so we are not tripping over each other and duplicating, which also can happen.

THE CHAIR: Thank you very much. We could have given three times as much time to this and still not covered all the things that we want to talk about. Is there anything that you have not covered or we have not asked you about that you would just like to make a final statement on?

Mr Lowen: Perhaps the one thing that needs to be borne in mind, and we have mentioned it in our submission, is that it is all very well to talk about these alternative care provisions—like practice nurses having more of a role and pharmacists and others having more of a role, but someone has to pay for it.

The commonwealth and Treasury should not turn around later and be surprised that there is then a blow-out in costs for those different allied health professions if they are going to have a role in working in collaboration or even providing a substitution of services. It is something that the state has to be cautious about. The commonwealth can really shape or wreck this space if we are not careful.

In building expectations around broader-based teams, we have to understand they have to be funded. There are very few item numbers that a practice nurse can access Medicare for. That means GPs still have to do a lot of work that could be delegated under their supervision to practice nurses currently. So I think there has to be a clear understanding that the commonwealth is still the dominant player in the funding part of the primary healthcare sector. It is important that we work together with them as one.

THE CHAIR: A final thought from our committee point of view: what we are looking at is, obviously, obtaining as much information as we can use to conduct our deliberations. The website has all of the submissions that we have received to date. They are published there, including yours. It will be on there, as are the exhibits. If there is anything else that you can glean from information on the website, we would appreciate any further feedback that you might want to give us. Thank you very much for your very detailed submission. I dare say the committee will be asking you some further questions in written format if that is okay.

Mr Lowen: Thank you.

THE CHAIR: Thank you for joining us. A full transcript of this morning's proceedings will be provided to you.

Mr Lowen: Thank you.

BATEMAN, Dr Edmund, Managing Director, Primary Health Care Ltd

THE CHAIR: Good morning, Dr Bateman, and welcome to this public hearing of the Standing Committee on Health, Community and Social Services, which is inquiring into access to primary healthcare services in the ACT. Have you had the chance to have a look at the privilege card that is provided to you there?

Dr Bateman: I have seen it.

THE CHAIR: You are comfortable with it?

Dr Bateman: Yes, thank you.

THE CHAIR: A very small housekeeping matter: if you have a telephone could you make sure it is on silent or turned off. Before we start, would you like to make an opening statement?

Dr Bateman: No.

THE CHAIR: We have received a number of submissions, and obviously there is concern with the superclinics. From your own experience—obviously, we are grateful for you coming along—what do you see as the trend? Are superclinics the way to go or do you see the standard GP practices that we have in place having a productive and useful role to play alongside all of the other alternative healthcare providers?

Dr Bateman: Do you want me to state my name first?

THE CHAIR: Yes, please.

Dr Bateman: I am Dr Edmund Bateman and I am the managing director of Primary Health Care Ltd, which is a publicly listed company. Do you now want me to go on and talk about superclinics?

THE CHAIR: Yes.

Dr Bateman: I think perhaps I should say where I have come from in terms of where I got to the superclinic, so called.

THE CHAIR: Certainly.

Dr Bateman: I graduated from Sydney University in 1965. I went to the Mater Hospital in North Sydney in New South Wales for three years. I mention that hospital because its interest was in general practice. It had a specific training program for general practice, which was a three-year rotational system. It covered all specialties and included casualty, outpatients and family practice as well. So you would see mum and the kids with the earaches et cetera and you would see people who had been hit by buses. So it was the full gamut and it was quite an educational training for GPs.

I then went into general practice on the northern beaches of Sydney in a six-man group practice or partnership. I was there for 10 years. That was a very good form of

practice. The other doctors in the practice trained me and I learnt from them. I learnt from experience. It was a practice in which you did your deliveries, you did your anaesthetics, you did house calls—you did all the things that are called "traditional" in practice. After a decade that practice broke up into individual practices within the same area. In other words, I didn't have a practice. I just changed from a partnership to a solo practice which I then continued for another 10 years or thereabouts.

At the end of that 10 years someone came along and said they were knocking down the building I was in. It was a big shopping centre on the northern beaches of Sydney. I thought about where I was at in general practice. General practice up until that stage had been pretty satisfying. You can deliver all your own children and do all that sort of thing for continuity of care. The problem was that gradually things were taken away from general practice. You had nurses in community centres vaccinating children, you had antenatal unit nurses doing antenatal care and postnatal care. You had obstetricians saying that GPs should not be delivering children; that they were the specialists. Therefore, you are out of the hospital. This doctor will deliver the children that you were delivering in the past. You had anaesthetists saying the same: "We are specialists. You should not be doing anaesthetics." So gradually general practice was coming down to what I called a medical certificate and a sore throat-type practice, which was not very satisfying.

I really then thought that I wanted a different form of general practice which is more satisfying. I really went back to the model that was the Mater hospital that I was used to, which was very stimulating and professionally very satisfying practice. So I then set up a 24 hour-a-day, 365 days-a-year practice. In other words, we were open every day of the year, all day. I brought in another GP who was in the area and we put our practices together.

We bulk-billed. Most people did not bulk-bill at that time because there was a lot of hostility to it. We were overwhelmed with work. The nature of the work changed quite significantly. It changed from what I have described general practice had become to a far more stimulating and far more rewarding type of practice. Weekends and evenings were like a war zone. If there was a football match on we were treating lacerations, foreign bodies, dislocated shoulders et cetera. We then needed radiology; so we put in radiology, not because we wanted to get into radiology. It was a very busy practice. A pharmacy wanted to come; so they came along.

Gradually we evolved into a busier and bigger model. That model today has about 90 professionals working in the one building. They are dentists, physios, podiatrists, nurses and pharmacists. There are 25 GPs; there are cardiologists; there are all sorts of specialists; there is a licensed day surgery. So it is very comprehensive in what it provides. It is all in the one site.

All the GPs who work there work only there and that is their full-time practice. The majority have been there for an average of 10 years or more. Some of them have been there for nearly 20 years. It has fully electronic records. It is complete. I can dial up and get a patient's record out of there from here in Canberra if I wanted to right now. Electronic connectivity is all there. We get images from radiology downloaded onto our desktops and we get pathology downloaded onto our desktops. I find that a very satisfying form of general practice. I think it is very good for patients. They can come

when they are sick, not when, sort of, the doctor wants them to come. Access is good, availability is excellent.

The problem is the things I brought up in my submission. So it gives you an idea of what I think about superclinics. As a result of going into that, I have been vilified personally by the AMA, by the president of the AMA, by the medical press, by the Murdoch press, by the Fairfax press and, you know, to some extent by you.

Basically, of course, sometimes this arises from a misunderstanding of where you are and what you are doing or a misconception as to how could this possibly work—there has got to be something wrong. It is a most efficient form of healthcare and it is also a most efficient form of use of the healthcare dollar. It is very hard to compete with it. So small practices just simply cannot compete with it because of the scale. But it is coming to an end in a sense that the funding for general practice is just inadequate. That is really the big issue that is just going to overwhelm anything you are thinking about or trying to do, in my view.

MS BRESNAN: Obviously, there are different models of care that we have talked about in the inquiry and also put forward in the submissions. You have mentioned one model of care. One of the issues I will also ask questions about is that issue of equity of access to care. Because of mobility or because of other issues—economic factors, not being able to get access to a GP or to hospital—whatever it is. How do you reconcile that? If we do move to this model of care with GPs, that does not suit some people, particularly around the outer access areas. You say that is the most economically efficient model but how do we reconcile that with the access issues that people then experience because of that?

Dr Bateman: Yes. There is always a trade-off in anything. Again, it gets down to the economics and the funding and what the community are willing to pay. If they are willing to pay for a small practice, then they can have everything that goes with a very small practice with great access to anyone who wants it at any time it suits them. And we do have small practices where people pay $120 for a consultation and they get in when they want to. Access is ideal for them but it is very expensive and is it realistic from a taxpayer's point of view? For the majority I would say not. The biggest barrier to access is cost.

Another barrier that is occurring is time. In other words, the waiting time is increasing as the supply of the doctors is decreasing. There is physical access as well but I think we deal with physical access as well as, or better than, most other practices either through legislation or just practically we do it.

MS BRESNAN: How do you do that?

Dr Bateman: We have wheelchair access and things like parking availability. But there is a limit to all of it, you know.

MS BRESNAN: Just quickly on that, there is one issue which has come up with us about those alternative models of care. There has been talk about nurse-led walk-in clinics and there has also been talk about community health centres. The access issue is still a problem. I know we can deal with it but there are still mobility issues for

people, particularly people on low incomes who might not be able to get to or from somewhere in terms of public transport. You said in your submission too that, I guess, you are generally not in favour of those alternative models of care. I guess my question is how do we still deal with—

Dr Bateman: I do not think I said that, did I?

MS BRESNAN: Okay. Sorry, that is what I assumed from your submission.

Dr Bateman: No, I said there are issues about—I go back again to the 80s when you had nurse-run, council-run vaccination clinics, for example. What happened then was that they looked after that. GPs start to lose interest in that because that was what the local nurse did. As a result, vaccinations disintegrated throughout Australia and then you had the government, under Wooldridge I think it was, bringing in item numbers to encourage doctors to vaccinate people because we had huge numbers of people not being vaccinated.

If you take it away from the general practice and move it somewhere else, it will start to disintegrate, in my view. If you take away the management of diabetes and give it to an endocrinologist, which is what has happened, the management of diabetes tends to disintegrate and people then throw their hands up in shock and horror and ask, "What is going on with diabetes?"

The answer is that GPs lose their skills in managing diabetics and lose their interest in managing diabetics. I really think general practice is the key to making it work. I think nurse clinics et cetera are quite a good idea provided they work in conjunction with a GP clinic.

MS BRESNAN: I will ask this because you mentioned the nurse practitioner being narrowly trained staff and that this could reduce positive outcomes for people.

Dr Bateman: The key to general practice is working out whether people are sick to begin with. I have said it in the submission. A nurse will ask the questions but not know the significance of the answers. For example, someone says to a nurse, "I have got a pain in the chest." What does it mean? I mean, a nurse will take the worst interpretation, I suggest, and send them to hospital or do an ECG. Yet if you have got the right training and the right skills, you might just say, "Go home and have some Mylanta or something." In other words, there is more to it than simply having an idea that this is how we get there. Nurses have great skills but they are narrowed skills. Some of the best doctors I have met have been nurses who then trained as doctors. The combination is fantastic. It is not very commonly met.

MS BRESNAN: Okay. I will finish here. The submissions we have had from other health professional groups have been about moving away from that solely medical based model and moving to a more integrated model where we do involve other health professionals, we do involve nurse practitioners, so that we are taking pressure off GPs because that is what we have also been hearing.

Dr Bateman: For more than 20 years in those superclinics, so called—in my model of practice—we have had a nurse always and at least two nurses in my original practice

for the very purpose that it lets me get on and do other work. But the idea that they would make the diagnosis and decide what should be done—that is where the problem starts to occur. But the problem is that when I start doing more work then Medicare comes along and says I am doing too much work.

The reality is I am doing more work that is more focused on where my best kills are and then the nurse is carrying on. So I used to employ the nurse. We still employ nurses to do a lot of work that allows us to get on with other work so we can deal with a lot more patients. I can deal with 60 patients while someone else deals with 30. So it definitely has a benefit.

Mr Hanson: Dr Bateman, thanks for your submission. It is very honest and very thorough. The question that I have relates to looking forward and dealing with the shortage that we have got here. That is part of what the committee is looking at and how we can cope with that. Do you see a role for Primary either in terms of an expansion of its current practices or in terms of new practices and a sourcing of doctors external to the ACT? Rather than necessarily a moving of doctors from practices currently in the ACT into a Primary Health Care practice I am referring to actually sourcing doctors externally. It is a question in two parts that relates to an expansion of your service here and then also do you have thoughts about enticing, encouraging, more doctors here to the ACT?

Dr Bateman: We have brought more doctors here to the ACT—not the majority of what we have got but certainly three or four. We have extended the life of some ACT practitioners by stopping them retiring and/or freeing them up to do more hours than they used to do. So we effectively have introduced more practitioners to the ACT.

I go back to an initial statement. I do not agree that you are shorter than anywhere else in Australia. That is the problem. You think you are short. I guarantee you that the problem you have got here is the same all over Australia. There is just the inadequate supply. This is a serious problem throughout and you are relatively well off.

I know the numbers that you have shown me but I just know that we recruit doctors for Elizabeth in South Australia to Murrumba Downs in Queensland et cetera. We have people recruiting doctors and buying practices throughout Australia. So we really do understand what the shortage is like. This is not a new shortage. Tom Wenkart is a doctor who used to run Macquarie. He had superclinics in the time of Eggleston. He wrote letters to the *Sydney Morning Herald* 20 years ago saying there was a shortage of doctors.

At that time they used to say, "Yes, it is a shortage in the country, not in the city." There was a shortage in the city at the same time. The problem is you have this financial incentive of governments to try and reduce budgets because they do not want to pay for it. They think the fewer doctors there are the less Medicare there will be. But the reality is we have the fourth best outcomes for healthcare delivery in Australia compared to anywhere else in the civilised world and we pay a fourteenth to a fifteenth of our gross domestic product to get it.

In other words, you have got excellent outcomes on the cheap. The problem is that it cannot go on being as cheap as it is. It is going to get more expensive. I know it is not

your fault; it is not your funding, but the funding of general practice is what it needs to happen. It needs to happen urgently and seriously. Everything else is moving around the periphery of the same issue.

The nurse item numbers that they have introduced are inadequate in funding. But even worse, some GP item numbers for the same service provided by a nurse are less. So you have doctors who are working and providing, item numbered, care equal to what a nurse does who get a lower Medicare rebate. You wonder why doctors are not wanting to go to the country and be GPs. It is just not realistic.

MS PORTER: I would like to follow on the access question that was asked by Ms Bresnan before. Given that access is extremely important, I was wondering if you could reflect on and give us some reasons around the decision to move the Wanniassa medical centre—why you thought that was so essential. There were a lot of people in that area that found access to the new centre difficult, as was told to us. Also why did the premises remain closed? We were led to believe that many people would still prefer to actually access a GP or GPs at that particular location. That is my first question.

My other question is that pharmacists have presented a case that it better suits them to be able to be front-line providers and to be able to prescribe as well once they see people. Do you see any additional role for pharmacists to ease this particular load of access?

Dr Bateman: The pharmacists are the greatest lobbyists in this country. They are not doing anything to help healthcare other than help themselves, in my view. I have just lost a whole lot of friends. But honestly, that is the situation. A pharmacist is less trained, really, in making these decisions than, say, a nurse is. I would suggest that a vet is probably a better person to go to to get advice than a pharmacist.

It has been an industry that has looked after itself to the cost of the community. We are paying for drugs when we do not have to pay the price that we are paying. That is the reality. I can buy flu vaccine for $7 and they are selling it for $23 to $24. And you are paying. I am just using an example. They will look after themselves. They have restrictions on licences which limit where they can go.

Coming back to Wanniassa, we are actually using the premises for our business already. I think it is open, unless I have been misled about that. I think it is currently operative. So we are using it. Why did we move? We moved because if we did not move we would close it in the end and the Phillip practice would not be viable as well because there is inadequate funding for general practice. This is not new. As I have described, this is ongoing. This has been occurring for decades. There is an effective reduction in the funding for general practice by the federal government year after year.

There is a one to two per cent increase in the rebate for the standard consultation. I think the cornerstone of general practice is the standard consultation. That goes up one or two per cent every year in November. The cost of running a practice goes up three to four to five per cent every year, year after year. So what we have is a gap of two per cent per year effective reduction in the rebate for a GP.

At the same time the GP's cost of living goes up, three, four per cent depending on all the usual things—petrol, school fees, the things that we need to live. So we have this increasing deficiency which in my view is in the order of a 20 per cent reduction effectively over the last five years. We have a GP consultation rebate of $35 roughly when you come to see me as a GP. A private billing doctor in Sydney or in lots of places is charging $65 to $120 for the same service. So you are getting it for half price.

How do we maintain it at half price? Either you give a lousy service or you increase the scale. In other words, instead of six doctors sharing the rent at Wanniassa and 10 doctors sharing the rent at Phillip, we have 16 doctors sharing the rent at Phillip. That is how we can keep going and make it viable. But if we do not, it falls apart. It is the same reason single practices have become two and three-man practices. They just cannot keep going financially, let alone emotionally, let alone maintain continuity of care. Economically, it is inevitable.

MS PORTER: The range, though, would be more, would it not, because you would need a larger premise, if you are going to have 16 doctors—

Dr Bateman: I will go back to the model at Brookvale, which is a bigger model. Say 100 people are sharing and the rent there is a million dollars. That is $10,000 per professional. Go to a small practice down the road, they are paying $50,000 a year for rent. So there is $40,000 a year difference per doctor, which is $4 million in a big centre. You can see the economics. The only way you can make the small practice viable is to give them a subsidy of an extra $50,000 a year just on rent. The same principle applies for everything—supplies, insurance, staff, the whole lot.

THE CHAIR: Dr Bateman, obviously you are talking about supply and demand as well. There is a need for doctors in the whole Tuggeranong area. Did you refer to the fact that your doctors, if I understand correctly what you said, in Phillip were not getting enough walk-in business? Is that part of the problem, or—

Dr Bateman: Not getting enough?

THE CHAIR: Well, what I am getting at is that you were saying that you had doctors that you needed to move from one location to another, but is the supply and demand in those locations a factor that you take into account as well?

Dr Bateman: The supply and demand for doctors and patients, or what—

THE CHAIR: The supply of doctors for the requirement of patients.

Dr Bateman: Where we go tends to be where we can get physical space to actually set up the large-scale clinic. We go where there are people. We do not go where there is a brownfield development down the road and there will be people there in 20 years time. We go preferably where there are doctors as well so that we have got people to come in, or where there are doctors nearby who can come in. Bringing in doctors from outside generally is not very productive. It does not work; it is very hard work.

THE CHAIR: You have also outlined quite a number of areas where you feel there is government red tape that impacts on the viability of the business as well and that you

could be employed more productively. Are there any specific areas of red tape that you could recommend that could be cut from a local point of view? I understand it is federal as well as local.

Dr Bateman: I must say that I think most of it is federal. I do not think really locally you are doing much, other than giving me aggravation from time to time or making me come down here. I think it is a federally driven thing with the local people trying to change it, which is very difficult to do because you are not the funder. You are not the director of where it is going. You are just trying to understand where it is, how it has happened and where we are going.

It is unfortunate that single practices, which I loved, are now no longer existing. It is the same as the corner stores. They have become Woolworths. But Woolworths at the same time gives you a range of choice that is available and prices that are competitive. It is a balancing trick.

MS BRESNAN: My question is about the balancing, about the range of choice and the continuity issue. One of the issues we have heard about from consumer groups and also from the Health Service Commissioner this morning is continuity of care, continuity of access for people, particularly people who have chronic conditions, and having that history known by the person you are seeing. This is particularly the case when we have been taught about GPs being that sort of primary point of access.

I am pretty sure it is what you are saying—that federal funding does affect really very much what happens. But how do we deal with that continuity of care and the continuity of access issue when we move towards this more, I guess, superpractice-driven model of care for people?

Dr Bateman: I think my model has greater continuity of care than the small practice.

MS BRESNAN: How is that?

Dr Bateman: For a start it is open 365 days a year. A small practice is open, say, 260 days a year, or whatever the number is. But we are open between seven in the morning and 10 at night, but he is open between eight or nine in the morning and five or six at night.

MS BRESNAN: Yes.

Dr Bateman: Half the time small practices are not there, whereas all the time, relatively, we are there. People get sick mostly between six in the morning and nine at night. That is statistically what actually happens. We are there when they get sick; there are common records; their full time doctor is there when he is working and the records are available to anyone who wants to come here. So you have got your choice of doctor. He shares the after-hours and weekends; so there is not some alien who is looking after you on the weekends. They see what has happened to you, they know what has happened to you and it is their full-time practice. They are not part-time people.

MS BRESNAN: I know you are saying that they share the records, but it is also about

that personal relationship that a patient shares with their doctor as well, particularly, I guess, for conditions where that element of trust is very important for people. Is that still something you are able to do in the practices you operate?

Dr Bateman: Just because Dr X comes into our clinic, he does not change, grow two heads and not be the doctor that he was before.

MS BRESNAN: No, I am not saying that, but I—

Dr Bateman: When you come, you can nominate your doctor. Monday to Friday, nine to five, 80 per cent of people at least nominate the doctor they want to see—their doctor. Of the balance, the other 20 per cent, half at least of those would have a doctor at the practice whom they really wanted to go to when they wanted to see someone, but today they just want a certificate, or whatever it is, for a sore throat and they will see the first available doctor.

I would say 80 to 90 per cent see their regular doctor, have their regular doctor. They often will, over time, evolve to have a second doctor or a second choice—"perhaps I will have my Pap smear there and I will see Dr Bateman for most of the other stuff". They have second choices as well. It is traditional general practice. It just has bells and whistles that make it better for everyone. That is really what it is. The idea that the solo practice down the road is something different is not true.

THE CHAIR: Dr Bateman, we are running close to the end. Have you got time to take a couple of more questions?

Dr Bateman: Yes.

MR HANSON: The systems you have got for e-health within Primary Health Care, sharing the records and so on, how advanced is that? The ACT government, I guess, will at some stage bring on its own e-health. Have they started discussions with you in terms of how those records may communicate with each other? How do you envisage that happening, if at all?

Dr Bateman: Our records are all fully electronic. In other words, there is not any hard copy. The only hard copy that comes about is hard copy that comes in from outside. All the hard copy that has come in has been brought in by a practitioner who has brought it with them. Day to day, as time goes by, it is fully electronic. Generally, that suits our purpose fine. In terms of what else would we like, there is a great sort of push saying, "Well, we should connect to the local hospital." The majority of general practice does not relate to a lot to a hospital anyway.

The majority of patients who come to this sort of general practice do not go to a hospital for most of their care most of the time. Hospital is a one-off event for the vast majority of people, or end-of-their-life type of event. So what are we getting back from hospitals? We get back discharge summaries and things like that. You can download those. That is not a big deal. They have done trials in Queensland on medical director, which we own. It is software for GPs; 85 per cent use it. They connected it with hospitals in Queensland to see how it would work.

The issue really is the quality of the records. There is a full range from dreadful to excellent. If I am working in a hospital in Queensland, or wherever it would be, am I going to rely on the records of some doctor I do not know or even if I do know him? Most doctors want to do it again and will do it again. So the idea that you are going to save duplication, everything is going to so much better—the answer is it is not as good as you think.

MR HANSON: In terms of the patient history, for example, let us just take the case of an elderly patient that turns up to the emergency department with a serious complaint. Do you envisage the ability where the emergency department at a hospital would be able to get access to those records electronically quickly to see what the underlying issues are, what the history for that patient might be? Although the doctor obviously admitting the patient would do his own diagnosis, that sort of background information could be useful. Do you see its progression to that level or not?

Dr Bateman: I agree that that is where we should be heading. I have got no problem with that. I just think that what you think you are going to gain from it is probably not as good as you think it is. That is all. I am not agin it. I think it is a good idea. The main benefit is to get rid of the volume of paper and storage and that sort of stuff. That is the practicality.

Why did we go electronic? Just finding stuff is a problem if you have got hard copy everywhere. Misplacing it is a problem. So again it is just the practical things that make it worth while. Mostly you ask the patient what the history is and they will tell you. They know exactly what their history is all about.

MR HANSON: I will follow up on that. When computers came in I think we all thought that this was going to get rid of all the administrative work. I think I get more now with the advent of computers, laptops, Blackberrys and so on. Have you had an experience of where doctors are less encumbered by red tape because of e-health or is it just the same but it is a different format that they have got to input the data into?

Dr Bateman: It is the same, you know. The quality of the data going in is the key to what it is about. "Rubbish in, rubbish out" is traditional, and that is absolutely true. It is the quality of the doctor and the quality of what he puts in that really matters. The thing is you have got to train people and you have got to educate them. You have got a whole new system. Software is a major problem. It is another management problem.

MS PORTER: I just wanted to pick up on the testing again. Surely if a person came in and they just had a cholesterol level done yesterday or they had a record that they had just had it done this week, that would not need to be done again. You are only talking about people whose tests and things are some time back, surely. I mean, the test is the test is the test. It does not really matter who has prescribed it when you get the test result back, surely.

Dr Bateman: All right, you come in with cholesterol and the cholesterol is probably not going to be that relevant for the hospital admission anyway, is it? I am just—

MS PORTER: I am just talking about that as an example.

Dr Bateman: Was the cholesterol fasting or not fasting? Who was the doctor? The sequence of the cholesterol is probably more important. What was the HDL? In other words, it is not as simple as you might think. Obama is saying that he is going to bring in e-health and spend $20 billion on it. I just think someone has been whispering in his ear—probably Bill Gates.

You know, it is a lot of money for some people but I honestly think this is not the beginning of the way to fix it. The way to fix it is to fund general practice and get more GPs working longer and harder and smarter. And nurses—I do not want you to get the idea that I think nurse care is a bad idea. I think a lot of doctors do not like it. They feel fearful of it. They feel threatened by it because they think you are going to take the work away. They cannot deal with the work they have got. That is the irony of it. It is a matter of what they are going to do, how they are going to do it and how they fit into the team, that is all.

THE CHAIR: Dr Bateman, thank you very much for your submission, as well as for coming in today. We appreciate that. Do you want to make a closing comment about anything that has not been asked that you were hoping to be asked about?

Dr Bateman: I put a fair bit in the submission. That is why I did not make an opening statement.

THE CHAIR: Sure.

Dr Bateman: I am happy to deal with anything on the phone or anything you like in the future.

THE CHAIR: The committee may have some questions to ask and we will do that in a written format, if that is okay.

Dr Bateman: Okay.

THE CHAIR: We will try not to add to your red tape.

Dr Bateman: Thank you.

THE CHAIR: Thank you for coming in.

Meeting adjourned from 10.53 to 11.08 am.

WELLS, MR ROBERT, Director, Australian Primary Health Care Research Institute, Australian National University

THE CHAIR: Good morning, Mr Wells, and thank you very much for coming to this public hearing of the Standing Committee on Health, Community and Social Services into access to primary healthcare services in the ACT. There is a privilege card in front of you. I am not sure whether you have had a chance to look at it.

Mr Wells: I have seen that.

THE CHAIR: You are aware of it and you are quite comfortable with it?

Mr Wells: Yes.

THE CHAIR: Thank you. Before we start asking you questions, would you like to make an opening statement?

Mr Wells: Yes, I would. First of all, thank you very much for inviting me to present to the committee. I think this is certainly a very important inquiry and it raises major questions for future health care in the ACT.

First of all, I have a couple of comments. The Australian Primary Health Care Research Institute is funded by the federal government to commission and undertake research into primary care. We are based at the ANU but we actually have a hub and spoke model so we have—

THE CHAIR: Sorry, can I get clarification? You are funded by the federal government to get into this on a national basis or by geographic location?

Mr Wells: No, a national basis. We fund research in other universities which, in our model, I call spokes. The Australian Primary Health Care Research Institute has been running for about five yeas and we are looking forward to further funding from the federal government in the years to come. This is by way of background as to who we are. I can talk about some of the research which I think is relevant to this committee as we go.

If I could perhaps say a few words about the inquiry, the areas that perhaps I could most usefully inform on are, first of all, the ACT GP shortage, how we might attract and retain general practitioners in the ACT, and, secondly, the system. It seems to me this is within your terms of reference.

We probably need to rethink our health system in the ACT. I know that is a longer term objective but there are probably some more immediate things that can be done. I think there are some questions within the ACT on issues about the movement of, particularly recently, general practitioners from suburban locations to consolidating in the town centres. They are the sorts of matters I think I could usefully bring some information to bear on.

THE CHAIR: Thank you. For your information—you are probably aware of this—there are a number of submissions that this inquiry has already received and some of

these have been published on our website.

Mr Wells: I have seen those ones, yes.

THE CHAIR: There are some more to go, obviously. All of the submissions and the exhibit items that have been presented to us will be on there and may be useful for your research on this point.

Mr Wells: Yes, thank you. I have accessed some of the ones on the web already.

THE CHAIR: Can we ask for your view on the primary reason for the current GP shortage in the ACT and do you believe that the ACT may be disproportionately affected compared with the other jurisdictions that you are looking into?

Mr Wells: Yes, I think it is. There are various figures that are thrown around and I do not particularly want to comment on those. The measure I most usefully use is the rate of bulk-billing in general practice. The ACT has, and has consistently had ever since Medicare came in, by far the lowest rate of bulk-billing in Australia. Given that Medicare provides, if you like, a floor price for services, if the charge in the ACT is consistently above the floor price, I would suggest that there is a shortage. So I think yes, the ACT does have a problem that is greater than that of other major cities. Obviously we are better off than some of the remote areas of Australia.

I think perhaps some of the causes of that—and this is anecdotal, and some of the GPs I have talked to say this—are that there is a problem with some of the medical culture in the ACT, that the GPs in particular do not feel that specialists respect their role in the system and, once the patient is referred to a specialist, they are taken away, if you like, from the GP's purview, and, if something happens, then they come back. A number of GPs I have spoken to believe this is a bigger problem in the ACT than in other parts of Australia.

There are also problems, I think, just with Canberra's image. It is seen as a government town, perhaps not a very attractive place to come, and perhaps some of the efforts to recruit GPs could tackle that problem. Again, this is anecdotal evidence; I do not have any surveys or hard data to support that.

THE CHAIR: Again, anecdotal evidence has been presented to the inquiry by GPs that Canberra is a well-kept secret, in fact. For an average GP working in the bigger cities—Sydney, Melbourne—Canberra could actually be a very attractive place for them to come to. That is something that has been presented to us and is a slightly contrary view to what you have just mentioned. There certainly would be several points that you can compare.

Mr Wells: I do not think that is contrary. What I am saying is that I think the image outside Canberra is that it is not an attractive place, but I think those in the ACT know it is the nation's best-kept secret. I have not had a chance to check this data and I am not sure whether they would be available, but the general trend is that GPs who work outside the major metropolitan areas actually have higher incomes than GPs who do not. I think that would probably apply to Canberra as well, particularly given that a fair proportion of the ACT attracts those extra benefits under the federal

government's workforce shortage programs—not all of them but some of them. So I suspect it is actually a place where you can earn more money as well.

MS BRESNAN: We have had quite a different lot of submissions and evidence provided about using alternative models of care and moving away from the medically elite model of care. Have you done any research into those different models of care which we could apply?

Mr Wells: Yes, we have. In fact, I would like to—and I can table this—give you the references. Our group, through another group at the ANU, recently produced a report on nursing in general practice: *Charting new roles for Australian general practice nurses: a multi-centre qualitative study*. That report was released only about two or three weeks ago. It was a result of nearly three years of studies of the various roles of nurses in the ACT and around the region. They found that in fact most of the nurses in general practice now are used for administrative roles—they are often the receptionist or they are the administrator of the practice—and for some clinical work, particularly with regard to immunisations and some wound management which, of course, reflects some of the federal funding that has come through in recent years tied to those services.

But this study found that there are six key roles of nurses beyond those they could take on. First of all, there is patient care. The nurses are very good for this work, being a carer of the patient, looking after the patient's whole needs over a period of time rather than just the "come in for a 10-minute consultation and out you go". They are good at quality control within the practice in monitoring the patient's progress across the practice, not just for the patients they are involved with themselves. They are good organisers.

They are good problem solvers; so they are good at working with doctors and other people in the practices. They say, "This is a knotty problem. How might we deal with it here with regard to a patient or a group of patients?" They are good educators that work within the practice, particularly with educators for the patients of the practice. They tell them more about a disease, how better it might be managed, what they can do themselves, those sorts of things. It is not that doctors are bad at that but nurses are good at that and are often used in that role. They are very good at what this study called connectivity. They are agents of connectivity, which really means that they are good at linking into the community and linking between patients, community groups and the practice.

This study shows that in fact there is great potential to use our nursing workforce to a much greater extent. This is a three-page summary of the work, and I am happy to table that. The full report is available on our website, APHCRI.

THE CHAIR: And you would be comfortable with us having that published on ours?

Mr Wells: Absolutely, yes. That is public. It has also been published in the *Medical Journal of Australia*; so it has got some credibility, if you like, as a peer reviewed publication.

MS BRESNAN: I have a quick follow-up. Obviously, as you know, one of the

initiatives in the ACT is the nurse-led walk-in clinics. In terms of what you found through that research, does that then translate to that model of care where it is nurse led and the nurse practitioners are leading that type of service?

Mr Wells: One has to look at how one would approach nurse-led clinics. One model is that they are a siphoning mechanism within the hospital to triage people who might otherwise just turn up at an emergency department. That is a useful model. But in primary care they probably need to be more closely linked with the broader primary care sector and particularly with general practitioners and other workers. This is based on my reading of the evidence in Australia and overseas that nurse-led clinics in the primary care sector away from the hospital would be better integrated with other professions and not just another stream of a professional group you would go to.

MS BRESNAN: Do you think having it located at a hospital might possibly lead to it being the siphoning model rather than the more integrated type model?

Mr Wells: I think so, yes, but that is not to say that it might not be a good thing for the hospital, and one might need to say, "We will have one at the hospital and its role is specifically around this function." But if you were then to have another one in the community, one would need to redefine its role and its links with the rest of the sector. That is really what I am saying. The United Kingdom has introduced some nurse-led clinics in the community sector, as distinct from the siphoning measures in hospitals, and there is evidence to suggest that they work quite well.

MS BRESNAN: We have heard some contradictory evidence about how well they have worked in the UK.

Mr Wells: You probably will get contradictory evidence because it is early days. Again, there is published evidence to suggest they work well but there is also anecdotal evidence that they take a lot of pressure off the GPs and that patients have better access so they are happier. You can perhaps get a better spread of hours and deal with the more easily dealt with problems quickly and then refer on to the doctors who want to manage your diabetic condition or complex chronic conditions.

MS PORTER: A number of submissions have spoken about poor access to GPs, both by location and cost of service, the lack of bulk-billing et cetera. This is put alongside the recognition that a person running a GP practice is running a business and they obviously have certain costs that need to be applied to remain viable. Do you have comments about those two concerns and how they can be aligned? Also, do you have any further comment on the movement of practices from suburbs into town centre locations and large, managed practices?

Mr Wells: On the first point, the level of bulk-billing nationally has increased. As I said earlier, the ACT is still low. It has been pretty stable in the last five years or so. I have that data. If people want them I can give them to you. But the actual cost of the copayment that a patient incurs when there is a copayment charge has gone up. I do not have a figure for the ACT but nationally that figure is now, for a general practice, about $25 to $30, which is a significant copayment for many people. If you combine that in the ACT with low levels of bulk-billing it is clearly a problem.

I do not think this problem can be fixed simply by perhaps upping the Medicare rebate or whatever, because there is some recent evidence that, when the government tried to do that with obstetrics, because of supply, shortages of doctors, they just add that into the factor and the copayment does not go down. So I think there are perhaps other models that need to be looked at. These are probably beyond the ACT's jurisdiction to deal with because they are to do with the way Medicare is funded.

The National Hospital Health Reform Commission, which issued its final report last week, suggested that for some models, particularly for selected groups of patients—for example, people with chronic diseases or people with young families—there might be other funding models that are more appropriate and perhaps more capitation based; that is, the practice gets funding for the patient, based on a risk-rated funding model and then the practice is responsible for managing that patient's care. Again, that is a model that is quite common elsewhere in the world, particularly in the UK.

There is evidence to suggest that the incentive then for doctors is to actually look after the practices, to use all the health workers or health resources they need to do that and keep people out of hospital as much as they can. Given that Australia has one of the highest rates of hospital admission in the Western world, that would seem to me a worthy objective. So yes, I think we do need to look at that and, if this committee felt it wanted to make some comments, that would be very useful because essentially our fee-for-service based model is not really the best way of looking after our changing disease and ageing profiles.

On the second question of movement, I think that is a trend that perhaps is occurring for reasons to do with consolidation. Again, there is evidence to suggest that practices which have more than one general practitioner tend to be able to provide more comprehensive care than solo practices. The ACT, in fact, has one of the highest consolidation rates. I think we have, proportionally, the highest number of practices with five or more GPs.

From a service provision point of view, that is actually a good move because if the practices are large enough they should be able to—I am not saying they do—extend their hours, for example. They should be able to improve their access in terms of how they schedule appointments, more fast-tracking and that sort of thing. They should be able to employ practice nurses and have better links with other health professionals to give more comprehensive care. I think the movement to larger practices from a clinical perspective, if you like, is a good move.

The consequence of that in the ACT, of course, has meant a taking away of practices closer to where people live. I think perhaps the way to deal with that problem is not necessarily to seek to have doctors go back to solo practices in smaller centres but to look at the groups who are most adversely affected by those changes and see what specific measures might assist them. In the long run they might actually get better care if we have more consolidated practices. I forget which body now but one of the submissions talked about better transport and actually targeted transport to get people from home to the practice.

They are my comments on that. It might be a worldwide trend and one that current funding models are actually supporting. You might be going against the tide, if you

like, trying to reverse it. And the cost of reversing it could be quite high. Some measures might do that. Given that attracting doctors to a more efficient business model might mean providing them with premises in the local centres, that would be a cost to the taxpayer. Or give them some other incentive to stay where they are or to move away from the town centres.

I also gather, if I can just add to that, from some of the submissions that part of the problem with the move to the town centres is that they are actually not to the town centres; they are to the service areas nearby. And, of course, they are not as easy to access by public transport as the town centres themselves. So that might be another problem. I have not really had a chance to look at that in detail but the GP task force might be looking at that; I do not know.

THE CHAIR: One of the common themes that most submissions seemed to have carried relates to, apart from a shortage of GPs, which everyone seems to be agreed on, the fact that, to compound the problem, there seem to be a lot of complaints about the red tape or the perceived red tape that exists—from a federal point of view, mainly, and I guess there are some local issues as well. With your research, you are in a fairly unique position to be able to identify some of those areas of concern and perhaps make some suggestions. Have you looked into this at this point?

Mr Wells: We have not looked specifically into that. I think it is an area that perhaps we could look at in the future. But it is interesting. We funded a number of projects in rural areas and identified the problems of practices in large rural towns, small rural towns et cetera, and that has not come up as a big issue, interestingly. I notice it has come up as a big issue in the ACT. The ACT health discussion paper addresses it as well.

I agree. I think anything that distracts the healthcare providers from providing healthcare and gets them tied up in filling in forms or seeing people simply because they have to have a certificate to cover their work absence or whatever is not a good idea. The more that that can be done, the better. There is probably a fair bit of that that can be done in the ACT because a lot of people are employed by the government. So governments can perhaps make some of those things easier. You have to have a doctor to give you a certificate.

I do not know what the arrangements are in the ACT government but, for example, at the ANU, with our workplace agreement, you do not have to have a doctor's certificate or a nurse's certificate for an absence, I think, of less than five days. We do not feel we are being ripped off by our staff. I think there are practical things that could be done to reduce that and certainly several submissions—

THE CHAIR: The red tape relates more to the requirement on doctors to attend to reports that they have to write on various areas and the certification they need. Some need up to eight areas of certification. All of that requires continual maintenance and information flow.

Mr Wells: That is right. Some areas of workers compensation and accident compensation et cetera are very bureaucratic in terms of forms to be filled in. But the Medicare item that was supposed to help doctors provide more comprehensive care,

the enhanced primary care item, actually imposes a fair bit of red tape on those doctors. Again, if one were to look at a more flexible funding model of, say, capitation, we would not have to be accounting for each item of service. You are more accounting for the patient's outcome against some agreed measures. So that too might help reduce the red tape. But it is a big problem. And of course then there is all the normal business red tape around just running a private practice, which is quite onerous.

MS BRESNAN: One of the issues which have been brought up by a couple of people is the issue of the ACT being within a region and having quite a lot of people coming from outside to use health services. It is those arbitrary boundaries which we always look at. We look at other cross-border areas as well. There are not a lot of similar areas in Australia. Albury/Wodonga is one; the Gold Coast/Tweed is another. Have you done any research on that where you have those cross-border, regional issues that then impact on the type of system which is provided?

Mr Wells: No, we have not. The impact of those, of course, has been more on the hospital system because people tend to come here for hospital services.

MS BRESNAN: We also heard it from Winnunga, obviously because they get a lot of Indigenous people using their service as well.

Mr Wells: Because of the Aboriginal population, yes. That could well be a factor. I am not sure it is a big factor if you are looking at primary care overall in the ACT.

MS BRESNAN: It is more the tertiary.

Mr Wells: But it is anomalous, I think, that we have this. But there it is. That is our federation, I think.

THE CHAIR: With your research, have you taken into consideration any of the models of primary healthcare delivery that exists overseas?

Mr Wells: Not in a comparative sense. Most of our comparative work has been with the United Kingdom and, to a lesser extent, with Canada, but principally with the United Kingdom. The models there tend to be more along the lines of where Australia is heading; for example, those general practice superclinics the federal government is rolling out with the larger practices that I described earlier with multiple health professionals employed in the practice.

But I do not think there are any models that we are aware of that would suggest we have got it radically wrong or that the trend where things are heading in Australia is out of sync. Indeed, the ACT is heading in those same directions as well. But no, I am not aware of any other models that I might point to and say, "What if we did that?" There might be, of course, for unique groups, but none come to mind in our work.

THE CHAIR: I think we have reached a point where time is going to restrict us. Is there anything else that you would like to add before we conclude our discussion this morning?

Mr Wells: There is just one other point I did want to make. In terms of attracting GPs to Canberra, I think the ACT has a number of strengths which we tend to overlook. First of all, we do have quite strong medical and other health profession training here across the two major universities, the ANU and the University of Canberra. I think we have opportunities to perhaps, as a one-off, well-contained jurisdiction, try to negotiate with the federal government some better models of funding. The National Hospital Health Reform Commission has certainly suggested some of that. If the federal government were of a mind to look at some large-scale trials—

THE CHAIR: A template and a model that could be utilised elsewhere?

Mr Wells: Yes. The ACT would be an ideal place. I am not suggesting the ACT should become a laboratory or whatever but we do have those strengths and there is a lot of evidence to support some of the different funding models et cetera that the commission has supported. So it would not be high risk to residents of the ACT and we might get a more efficient and effective service. That in turn, I think, would provide a more attractive proposition for people, not just doctors but other health professionals, to come and work here; they would see a bit of a go-ahead place.

Importantly, the ACT government could perhaps make a policy statement that primary care is the centre of our system. I do not think that has been made. Certainly, if you look at the current activities of the ACT government, they are putting a lot of money into Canberra Hospital and buying another hospital. I am not objecting to that. But I am saying that the message that sends out is that we have got a very hospital-centric healthcare system; so if you are a general practitioner why would you not come here?

THE CHAIR: Thank you very much. A full transcript of the hearing this morning will be given to you. In fact, one of the points that you mentioned was in regard to the five-year data set that you may have. If you would be willing to share that with us, we would be very interested to see those.

Mr Wells: Yes, certainly. Everything we have funded and that is completed is available on our website, all the reports, and they are available in a format which is called a 1, 3, 25. There is a one-page summary of the work; three pages, with more detail, which I have given you about the nursing one; and then a 25-page one, or it actually can be longer, on the detail of the work that has been done. They are in a form that, if people want a quick overview, want to know a bit more about it or really want to get into the detail, they can look at it. And they are all on our website. They are all publicly available.

THE CHAIR: Thank you very much. We wish you well in your research. If you come across other areas that you think may be of interest to this committee, we would certainly appreciate you letting us know.

Mr Wells: I certainly will. Thank you very much for your time.

THE CHAIR: Thank you.

HEKIMIAN, MR DAVID HRATCH, Coordinator, the Junction Youth Health Service
LE RICHE, MS PAULINE, Health Manager, the Junction Youth Health Service

THE CHAIR: Thank you very much for joining us this morning at this public hearing of the Standing Committee on Health, Community and Social Services into access to primary healthcare services in the ACT. Have you both had a chance to have a look at the privilege card?

Mr Hekimian: Yes, we have looked at it.

THE CHAIR: And you are comfortable with it and understand what it means?

Ms Le Riche: Yes.

Mr Hekimian: Yes.

THE CHAIR: Thank you. Before we start, would either of you like to make an opening statement?

Mr Hekimian: I will just give you a quick rundown on who we are and what we do. We both work at the Junction Youth Health Service. I am the Coordinator of the Junction and Pauline is the Health Manager. The Junction is a free health service for young people that has been going for over 10 years now. It was originally established because there was a finding that young people, particularly marginalised young people, were not accessing GP services.

So a youth friendly GP service was the goal. That took off 10 years ago and it has just got bigger and bigger as we have progressed. We offer GP clinics, nursing clinics, counselling clinics and youth work services. We run from Monday to Friday. We are open from one to five each day and we are continually booked out.

That is the standard service that we offer but recently we were given funding to develop some outreach programs. But we are the only youth health service in the ACT. We have got funding to run outreach programs into the Belconnen, Gungahlin and Tuggeranong regions. Through that funding we have established two teams. Each team has a nurse and a youth outreach worker.

The idea for those teams is to build partnerships with the schools, youth services and youth centres as well as GPs and other health services in the communities, with the goal being to connect young people to GP and health services in their communities. That has been going for just on a year now and we are experiencing moderate success with that. With the limited GP spaces available, the biggest challenge is developing those partnerships and getting those GPs to take our clients on board. That is it in a nutshell. We are happy to answer questions to provide further detail.

THE CHAIR: That was going to be my question. How has the GP shortage impacted on the work of the Junction? You mentioned space. Are you saying that you are providing space for GPs to come and work outside the centre or are you experiencing a problem with the lack of GPs? That is what I am trying to ask.

Mr Hekimian: Yes, the lack of GPs has been an ongoing problem. I think the ideal solution as far as the Junction expanding would have been to set up satellite junctions in those regions. There just is not the staff to run similar services. So instead of setting up other youth-friendly health services, the concept of this outreach service was created. That is one impact that the shortage of GPs is having on us.

The other impact is at our centre-based service. We are really fortunate that we have a GP who is willing to work there three days a week and that is actually the core of our service. That GP has been with us for 10 years now and so she has a wealth of knowledge and experience in youth health.

But the Junction also has other services. We provide inreach services like CARHU. The child-at-risk health unit, for instance, provides us with a paediatric registrar one afternoon. That is on a six-month rotation. So Monday, Tuesday and Thursday our GP covers the shifts. On the Wednesday, we are lucky enough to get this paediatric registrar in.

For the Friday shift, we had another GP working that shift until about two years ago, when she moved interstate. We have not been able to fill that shift. We have not even been able to find an expression of interest to fill that shift. It is a real challenge to get them to come out of their setting, and to come and work in our setting in a youth-focused service is hard. Even at the best of times it would be hard to fill that but, with the shortage of GPs, it is really challenging.

Ms Le Riche: Can I expand on that?

THE CHAIR: Certainly.

Ms Le Riche: With the 60 full-time equivalent shortage of GPs in the ACT, it is very hard. We only have Jocelyn, who is only three afternoons a week. If she becomes ill we have no GP. Jocelyn is actually going on holidays soon and I contacted the ACT Division of GPs for a locum. They have no-one on their books. I then contacted Sydney. We are looking at about $1,200 a day. We cannot afford that. We actually pay Jocelyn under what she is valued at because we cannot afford to pay her at a doctor's rate.

The other issue with GPs is that our nurses can only see clients and take pathology specimens off the client and administer medications as long as we have Jocelyn working on the floor; whereas the ACT Health nurses can work throughout the whole of Canberra and not work alongside a doctor, yet be signed off by a doctor of ACT Health. They work on standing orders but Jocelyn's insurance does not cover that. So it would be fantastic if in some way the ACT government somehow would assist our nurses to work in the satellite regions and be signed off by the ACT government.

THE CHAIR: Has this been brought to the ACT government's attention?

Ms Le Riche: In the last report that we sent to them, yes.

MS BRESNAN: When was that report?

Ms Le Riche: Last week.

Mr Hekimian: In the recent week.

MS BRESNAN: Last week?

Ms Le Riche: Yes. I have worked for ACT Health before as a nurse and I was not working alongside that doctor at all. That doctor did not know how I worked clinically, yet I was able to sign off for the clinical pathology that I required for my patients.

I think it is very hard for a GP who must be there all the time to sign off. They have actually got to sight the patient and then describe what needs to be done. We have standing orders so that the nurse can actually work through. A person will come in for a certain medical condition, they will work through the standing order and then grab the doctor, give a brief history, doctor pops her head in, says hello, double-checks on things, signs off and then the nurse continues with her work.

Our doctors are forever being interrupted. We actually had two nurses working alongside another doctor. She is trying to run her own consult, being interrupted by two other nurses constantly.

MS BRESNAN: And is that purely an insurance issue or is it related to—

Ms Le Riche: Insurance.

MS BRESNAN: In terms of the funding you are receiving, it is not connected to the funding that you get; it is basically an insurance matter?

Ms Le Riche: No, insurance—doctors insurance.

THE CHAIR: It is not a government regulation that gets in the way there?

Ms Le Riche: We do not believe so, no. It is purely her insurance—yes, her medical indemnity insurance.

MS BRESNAN: Is that something which has to be changed at the federal level or is it something which can be changed at the ACT level?

Ms Le Riche: Most probably at the federal level. We have the two outreach nurses doing the satellite in west Belconnen, Gungahlin and Tuggeranong. At the moment they are doing a lot of health promotion and educational programs and assessing young people out in the community that need to access a GP, especially the homeless and marginalised young people who actually fall through the gap of going to mainstream GPs because they do not feel that they are treated appropriately for their life circumstances; so they will not go there. Basically, by the time the young person becomes so ill, they end up in hospital, costing the medical system a lot of money because they have now got a chronic disease.

If somehow the government could cover the nurses to work out in the satellites as an

NGO, not ACT Health—

MS BRESNAN: Sorry for my ignorance on this matter but, when it is at the ACT level, how are those arrangements able to be different to what you do as an NGO?

Ms Le Riche: I do not have a full understanding but I have just been told that ACT Health have a standing order from their medical officers and they have very good insurance coverage.

MS BRESNAN: So it basically comes down to that. We have talked a lot during the inquiry and also through submissions about the different models of care that services provide. We have heard from Winnunga and from Companion House. I guess the Junction is another one which uses that more holistic model to engage with the particular people you are trying to target. Do you find that because you are providing something different that is why young people want to come to you or is it just that you are specifically a new service and they feel comfortable coming to see you?

Ms Le Riche: I think it is because we are youth friendly. The big phrase is youth-friendly service. With the outreach team and the issues they are finding, they are actually finding the young people who need to access mainstream GPs; they are taking the young person to that GP; and after the consult they are saying, "I am not going back there again. They did not treat me properly; they did not explain things."

These young people have quite complex issues. It is not a 10-minute consult; it is not a 15-minute consult; it can be anything from half an hour-plus. And GPs do not have the time for that; they are on time constraints. For them, it is more of a business.

MS BRESNAN: When you said you were finding those young people through the outreach centres and they do not want to go back, how do you then keep them engaged and how do you keep their treatment running?

Ms Le Riche: Usually the nurse now actually attends the appointments. If the young person requests them to actually come in with them, they will attend the appointment. Then the nurse actually spends more time with them afterwards, explaining what the doctor has said, makes sure they can get their medications.

We have had issues where young people have gone and seen their doctor and, through different issues, have been prescribed three different drugs. They cannot afford it; so they go for the cheapest drug; but actually they should have the dearest drug because certain medication was more important than the other two. Things are not explained to the young people.

MS BRESNAN: And are you finding, by having the nurse going along with them—

Ms Le Riche: Advocating for them.

MS BRESNAN: That is keeping them engaged?

Ms Le Riche: It is, because sometimes the nurses have said they have made the appointment for the young person and the young person was going to make their own

way to the GP but they do not turn up; whereas if the youth worker and the nurse collect the young person, take them to the GP and sit and wait or go in and have a consult with the young person, it actually works.

Mr Hekimian: The goal of the outreach program is to connect those young people to health facilities in their communities and to help them establish that link. And if it means us going with them for the first four, five or six visits, that is what we do; that is what the funding is for. Then, hopefully, they will maintain ongoing health care from that point onwards.

But yes, as I said, the program has only been going for a year and these findings are quite new to me. We are still experiencing that same issue where they are leaving a GP consult going, "I do not like that person; he was very judgemental; he did not treat me respectfully," et cetera.

You were asking how we are dealing with that. It is still so recent.

MS BRESNAN: So early, yes.

Mr Hekimian: We are yet to really formulate any ideas on that.

MS BRESNAN: Do you have ongoing funding for that, and will it include an evaluation process as well so that you can look at how it is going?

Mr Hekimian: Yes. At the moment, we are on a three-year contract that ends at the end of this financial year, but I could see that funding continuing for at least another three-year contract.

Ms Le Riche: And it is not just getting the young person to the doctors; a lot of these homeless, at risk young people, do not have Medicare cards. They have birth certificates—

MS BRESNAN: So it is a whole process?

Ms Le Riche: So you are going all the way back to try to find the birth certificate, apply for a Medicare card. They do not have the money for any of that; so we actually brokerage for these expenses.

MS PORTER: Do you think one of the roles that you might have, or someone might have, is education for GPs of the young people, particularly young homeless people? Is there a role in educating them more in what expectations a young person has when they actually go to the GP? That is perhaps a role for yourselves after you have done some of that research that you are doing?

Mr Hekimian: To educate the young people or educate the GPs?

MS PORTER: No, the GPs, not the young people. Obviously the young people know exactly what they want; it is the GPs where they seem to be not—

Ms Le Riche: It is not only the GPs that need to be educated; it starts from the

receptionist staff.

MS PORTER: In the whole practice, there needs to be some education?

Ms Le Riche: Confidentiality is also another issue. Some GPs may be seeing the family and we find out the young person's family is also attending that practice. We take them there. But certain GPs have actually breached confidentiality by then telling the young person's family what is happening.

Mr Hekimian: But in answer to your question, absolutely. Some education on youth-friendly GP services would be really beneficial. Getting the general practices to want to come on board to that is the challenge. It was about five years ago that the Junction did actually offer an education program. We got some specific funding for a project to educate GP services to become more youth friendly and, while we poured a lot of work into it over, I think it was, a 12-month project, the end result was that we got about two GPs actually turn up to the training.

Through all the networking, the liaison, the provision of information et cetera, the final outcome was that we had about two GPs turn up to the actual training offered. It just did not work. I was not involved in that; I just know about it. I am not sure why it did not take off but I know, again, one of the biggest challenges was getting the GPs on board.

MS PORTER: They have made several comments about being very time poor and the stress on them in being able to provide time for their actual patients to come to see them and the red tape. I have to smile about that comment, but how do they receive the person that comes in? Is there any resistance to allowing another person, not the person's relative or direct carer, to actually come with them into the room? Do you have any issues on that?

Mr Hekimian: I have not heard of any resistance. I am not actually out doing the work but I get a lot of feedback. That is something I have not had any feedback on. The bottom line is that if a client wants a support person, regardless of who they are, I have never heard of that being blocked in any way.

Ms Le Riche: The outreach team has actually gone out initially and made contact with GPs in that region, introduced themselves, explained what their role is and then brought the young people in. So they have actually made contact with certain GPs in certain regions so that they know what is going to happen.

MS PORTER: Have you any comments to make about the change to the scope of practice for nurses and allied health workers such as the nurses referring, the nurse-led clinics, the allied health assistant roles and the different initiatives that we have been discussing about those different models? Have you any comments to make about those particular models?

Mr Hekimian: Speaking from a non-clinical background, any progress in that area would be really beneficial to the Junction. It is easier for us to employ nurses than GPs. We actually have connections with nurse practitioners. That was the nurses' role, wasn't it, nurse practitioners?

Ms Le Riche: Yes.

Mr Hekimian: If we could get increased scope of practice for nurse practitioners, we could provide more health services to young people at our central base; similarly with increased scope for registered nurses as well. But that is from a non-clinical background. It would help us provide a better range of services to young people.

THE CHAIR: You talked about your clientele, your young kids, and you mentioned the homeless as well. Do you have any feel for the make-up of where these young people come from? Are they all Canberra-based people or do you get a lot of transient people coming from the broader region?

Ms Le Riche: The majority of our young clients are from Canberra but we do get a lot of transients. Quite a few of our Indigenous people are transient. Plus, we do see quite a few people come from other regions of New South Wales, from Queensland. Then usually by winter they have moved on again. But we are also looking after the children of the youth as well now. We are looking after the babies and toddlers and we see young pregnant females from the age of 11 and up.

THE CHAIR: Obviously what we are concentrating on is the GPs and the impact on various services. From your point of view, the status quo is that, for the number of people that are coming to see you, you can cope with the number of youth coming in. From what I understand, it is only if you have got someone away that that really impacts you. Is that correct or is the demand greater now than you can cope with?

Ms Le Riche: The demand is greater than what we can cope with. We actually turn—

THE CHAIR: So you are impacted by the shortage of GPs?

Ms Le Riche: Yes.

Mr Hekimian: Yes. We have a lot of turn-aways. Probably the average turn-away for GPs is about 50 a month, just as a ballpark figure. Those figures are a little bit confusing because sometimes they are turned away but they get back in the next week or something like that. So it is not as if they are turned away, never to be seen. But if they needed to see a GP that day and did not get to see one, we would consider that a turn-away. A lot of the outreach funding was based on those turned-away figures.

But yes, regardless of that, the areas that we are servicing are almost different clientele to the regular clients. So it is not as if the outreach work that we are doing has decreased the number of turn-aways. If anything, more people in the outer suburbs are learning about the Junction and, even though the goal is not to connect them to the Junction because we are already overbooked, they hear about us, they meet us, they see that is where they want to come for their health care, because they know that it is youth friendly, that they are not going to be judged and that they are going to feel safe at a place like the Junction. Having a support person to advocate for them, to assist with transport et cetera, is going to make that connection to GPs in their own communities easier. But a lot of the time their preference would still be to come to the Junction. So that work has not decreased the number of turn-aways.

Ms Le Riche: And to decrease the number of turn-aways, we actually now have two advanced practice nurses working alongside the GP. Before we only had one but because we had so many turn-aways we now have two. So the nurse can actually make assessments and decide whether she can deal with it or, once again, she will knock on the doctor's door and ask the doctor to come in.

MS BRESNAN: Are the majority of people turned away? In turn, would you say, "We'll go and see—

Ms Le Riche: No, we are still turning them away each day, as I have mentioned.

MS BRESNAN: The question I was going to ask you—and you have already answered that—was about clientele. I was wondering whether the people you are seeing in the outreach were different to the people who were coming into the actual centre. Are you finding that the people are possibly—it is probably not the right way to put it—a slightly more disadvantaged group than the people that come into the centre or is it a similar clientele? Is location the issue as well?

Mr Hekimian: No. My understanding is that it is a similar clientele. I cannot really answer that with 100 per cent certainty but it is the same. We are going to schools; we are delivering workshops and education programs and that; we are meeting all sorts of young people. But then the clients that are connecting with the staff and getting some assistance seem very similar to the clients, from my understanding, we are seeing at the Junction; they are the marginalised ones, the ones that do not have that parent support to provide them with money, access and transport to GPs. They are the ones that need that little bit of extra help to make that connection.

I guess that is what our funding is for. It is for all young people but to target the marginalised young people. So the ones that we are picking up out there in the communities would be very similar to the clients at the Junction.

But in saying that, also at the Junction, it is not just marginalised young people we are seeing. All young people need healthcare now. With sexual health, drug and alcohol and the mental health issues out there, that starts in early high school. Even the young people in well-adjusted, comfortable family homes et cetera still need a confidential youth family health service. So if anything, the demand is getting greater continually.

MS BRESNAN: Actually I was just going to ask about mental health. Is that one of the things you find? Is that one of the big groups of people you see?

Mr Hekimian: It is one of the big groups. We have three main areas, which are sexual health, mental health and drug and alcohol. That is the bulk of the work we do. We get people come in with a broken toe and a cold and things like that and that is a bit of relief from the complex work. The clients that we pick up and then stay with the Junction for longer periods of time are those clients with the complex health needs. It is not just one or two visits to a GP that is going to resolve those. It is usually one or two visits, to begin, to open up the doors into that health care.

Ms Le Riche: That is another issue with our young people. They do not want to go to

these major bulk-billing centres because they do not get to see the same doctor each time and they have complex issues. Instead of trying to discuss this main issue over and over again with a different doctor who may not understand it and not have the time, it is easier to go to one doctor who is not judgemental and has an understanding of what they are going through and explain their story once.

Mr Hekimian: Yes, that is one of the biggest things, having to tell their story over and over.

MS BRESNAN: And is that something you hear from young people? They say, "I am not going, for this reason"?

Ms Le Riche: Yes. You have got to remember that a lot of our young people have also been sexually abused or assaulted in their early lives as well.

Mr Hekimian: I have one other comment, quickly. Part of our funding agreement—and this is another way we are we are being impacted by the GP shortage—is to link young people up with GPs in the community from our centre-based service. We see young people from 12 to 25. On their 26th birthday they no longer fit our criteria. Part of our funding agreement is to then link them up, as they are reaching their 26th birthday, with a GP in their own community. But all the GPs have got their books shut. It is so difficult to find a GP that is willing to take on a young person, particularly a young person with complex mental health and drug and alcohol issues et cetera. So that is another impact that these shortages are having on the Junction.

MS PORTER: It seems to me that there are several factors that are impacting. It is not only the shortage of GPs but it is also the time—I guess that is also connected—and the nature of the practice, whether it is a large practice or a more friendly practice, the attitude of the staff and the cost of any ongoing treatment that might be recommended. Is that right? There is, more or less, the location, the type of service being offered, the cost and the attitude. Would you say that those four factors are influencing how a young person receives a service?

Mr Hekimian: Yes. They would all count but I would say the attitude of the staff is the most important one to young people. That is my view. All of those other things young people can deal with. They are very resourceful; they are very resilient. They will come from Tuggeranong to the Junction. Distance is not a problem. If what they want is there, they will find a way to get there. And as far as money goes, there are lots of services that offer brokerage to young people for various things. That is part of the service that we offer. So if they have a prescription written or something, we will fill that script if they cannot afford it et cetera. While those things are obstacles, I think the biggest one is the attitudes of staff. If they feel safe and non-judged at a service, that is a really big factor in this.

THE CHAIR: We are getting near the end of our time, but have we covered all of the points that you wanted to talk about? Is there anything that we have not looked at at this point that you would really like to make a closing comment about?

Mr Hekimian: I cannot think of anything just now.

THE CHAIR: By the way, do not feel constrained by that because our deliberations will go on. If there is anything else that comes up that you think we ought to know about, please let us know. Obviously, our aim is to get as much information as we can regarding how we can improve the number of GPs. If there are any other solutions that you may have—specifically in terms of young people, but overall—or if there are any issues or solutions that come to mind, we would be very keen to hear from you.

MS PORTER: What are you going to do if you do not find a locum for the doctor if she wants to go on holidays?

Ms Le Riche: She is going to be on holidays this time around. The clinic knows well before the doctor goes away. We will make sure that everyone whose immunisations are due and need to have their pathology tests all come. We will get Jocelyn to write all the files up for this so that there is work for the nurse to continue during that time. But also clients would still come in and see the nurse about whatever medical issues and we will then refer them on to other places.

Mr Hekimian: We will refer them to other places. We offer a triage-type service and, depending on their need, we will refer and provide further assistance such as transport and appropriate costs, depending on the urgency of it. I cannot think of anything to add now but if we do we will feed it back.

THE CHAIR: One member of our committee could not be with us today, but if we have any other questions we may put those to you in writing as well. We thank you very much for your submission and for coming in. We wish you all the best in the good works that you are doing. Thank you very much.

Mr Hekimian: Thank you.

CERASA, MS DEBRA, Chief Executive Officer, Royal College of Nursing, Australia
McLAUGHLIN, MS KATHLEEN, Director, Professional Services, Royal College of Nursing, Australia

THE CHAIR: Welcome. Thank you for joining us this afternoon at the public hearing of the Standing Committee on Health, Community and Social Services into access to primary healthcare services in the ACT. There is a privilege card there. I am not sure whether you have read it or whether you would like to take a couple of minutes to read it. Do you understand the implications of the privilege statement?

Ms Cerasa: Yes.

THE CHAIR: Fine. Would either of you care to make an opening statement before we start?

Ms Cerasa: I shall, thank you. First of all, we would like to say thank you for inviting us. We are delighted to be able to, first, put in a written submission and then have the opportunity to speak today. Would you like us to give you a couple of sentences on what the Royal College of Nursing Australia do and who we are? Would that be helpful?

THE CHAIR: Yes. Thank you.

Ms Cerasa: We are a not-for-profit, membership-based organisation and we strive to represent the professional voice of nursing across Australia in a very general, broad and diverse perspective. Through our membership base, we believe we have access to expertise and knowledge from a vast, diverse range of nursing and midwifery. Although the number of our members who are midwives would be small compared to colleagues at the Australian College of Midwives, we do have representation. We do not have a particular political alliance, religious alliance or any alliance with anyone in particular. We are very interested in the profession of nursing and what that represents and what we believe we can contribute to its progression and development into the future. Is that helpful?

THE CHAIR: It is.

Ms Cerasa: Good. Thank you for that opportunity. We would like to say that RCNA believe that nursing can contribute greatly to the benefit of the health and wellbeing of the Australian community. At the moment we believe that nurses, to their full scope of practice, experience and education, are probably not fully utilised. We see in the current environment an enormous opportunity to be able to develop and contribute to the Australian community through that scope of practice.

We think that the current reform agenda across Australia does lead to an opportunity to review the way that systems, services and the current design are being operationalised. We think there does need to be some reform because we know that we have the challenges of workforce. To that end we would like to make a couple of comments on the various aspects of nursing.

There are various levels of nursing that can contribute. There are nurse practitioners, who obviously enjoy quite a lot of media coverage at the moment. The level of education and experience of a nurse practitioner would be considered the most senior within the nursing framework at the moment. There are advanced practice nurses; there are practice nurses that work within a primary healthcare setting in general practices of mainly medical service delivery but they do contribute. We think there is enormous scope for the work that they do.

Certainly there are registered general nurses and our next level, enrolled nurses, and of course there is the workforce of unregulated workers where we know there are assistants in nursing working. RCNA would be very welcoming of the opportunity to be able to be involved in any development where we could see some education mandates and involvement in setting standards for that current unregulated workforce which we believe, when we look at current trends overseas, will definitely make inroads into the health system in Australia in the not too distant future.

From that perspective, we have got a number of areas we would be happy to talk to you about but I am not quite sure how you would like to direct your questions. Is that enough at this stage?

THE CHAIR: We generally ask for an opening statement. We have read your submission. Thank you very much for your submission and your outline of your activities. We will ask some questions and perhaps you can address them. If we have not covered some of things that you really want to cover, you will have an opportunity to do that as well. Is there anything further you want to say at this point?

Ms Cerasa: No, thank you.

THE CHAIR: Your submission outlines how nurses, particularly nurse practitioners, are currently being underutilized, and you have just stated that again. Why do you believe this continues to be the case and what kind of resistance exists to the introduction of nurse practitioners?

Ms Cerasa: First of all, we think there are approximately 360 registered nurse practitioners in Australia at the moment. It took a long time to get the recognition of nurse practitioners into our health arena. Currently all states and territories have different criteria by which to register a nurse practitioner. So there was considerable work done in gaining acceptance of this status and the experience and qualification of nurse practitioners.

Now that that has been achieved, we know that the large percentage—in very broad terms, 60 to 80 per cent of nurse practitioners—are still working in acute health. So we think if we can support nurse practitioners moving away from acute health and into primary health care settings and, therefore, lead more nurses to undertake that education and have their experience recognised and get them into that primary health care arena, we will increase the number of nurse practitioners.

I think that, with the funding, until now there has not been access to MBS or PDS; so we know that that is now being recognised as applicable for nurse practitioners. Once that is implanted, I think that will make a significant difference to nurse practitioners

being attracted to that arena.

I think the scope of practice is also very different. If we just look at general practitioners, as in medical general practitioners, and look at nurse practitioners, they do very different roles. One of the frustrations, I think, for people going to a general practice and needing a GP is often that the care or requirements that they need are such that they may not need a complex medical follow-up or they are fraught with the frustration of only being able to get a 10-minute appointment; whereas nurse practitioners working in that setting will often approach the care, the treatment or the consultation in a very different manner.

As yet we have not got a really good payment structure for nurse practitioners in that environment. I think that is very significant. The recognition of the scope of practice between the GP practice and the nurse practitioner practice and the payment model are significant.

THE CHAIR: Is insurance a factor as well?

Ms Cerasa: It can be. It depends on whether the nurse practitioner is actually employed by the practice itself. Under those terms of contracts you would make the assumption that they have got some sort of indemnity insurance. If a nurse practitioner was working independently and on their own, they would obviously have an obligation to maintain their own indemnity insurance. I do not know of very many. In fact, I think it would be a very small number of nurse practitioners that are currently working independently. Those that are, I believe, do have indemnity insurance. Sure, that is always a factor if you are setting up in private practice.

Ms McLaughlin: And if I can just follow on from there, I think there is a lot of misunderstanding on that and, therefore, general practitioners will often think that they are responsible for the care delivered by the nurse working in the practice when in actual fact the nurse is responsible for their own practice, according to the regulation of the profession. So there is actually a lot of misunderstanding on that. There is quite a bit of education and clarity required there.

THE CHAIR: Following on from this resistance regarding the introduction of nurse practitioners, can you give us some Canberra-specific examples of where these issues are worse in Canberra or where we can improve the introduction?

Ms McLaughlin: Between the two of us we probably would not have the specific Canberra location-based information.

THE CHAIR: Neither of you is based in Canberra?

Ms McLaughlin: We are based in Canberra but it is a national organisation.

Ms Cerasa: You want a specific example of a nurse practitioner that has had an obstacle and has not been able to practise?

THE CHAIR: I was wondering whether you have any such examples.

Ms Cerasa: Could I give it to you in reverse?

THE CHAIR: Certainly.

Ms Cerasa: Where I see nurse practitioners being accepted more willingly is in areas where there are marginalised communities. If we are looking at youth, if you are looking at women or if you are looking at the homeless, immigrants or areas where there is a specific need that can be targeted, we find that they are more readily accepted. And of course that makes for a very specialist nurse practitioner.

What we would like to see is nurses choose a career path that would make them a generalist nurse practitioner where they could work in harmony and complement the practice of a general practitioner because they would have such different scopes of practice. I do not think that we have actually been able to see the full diversity that could develop for nurse practitioners as yet. That is a kind of a reverse answer to your question.

For example, we have just had the good fortune to employ a nurse practitioner whose area of expertise is sexual health. Her clinical practice work over the last six or eight years has been working with, specifically, young people in sexual health; yet if she was working in a general practitioner clinic where she could broaden her scope of practice and expertise, it could be very beneficial to have a much broader women's, men's, youth health work experience in that GP practice. It could give access to another health professional in that practice-clinic setting. That is probably the first thing that juts into my mind.

THE CHAIR: That is good. Thanks.

MS BRESNAN: My question is leading off from that. Do you think that, with the establishment of the nurse-led walk-in clinics, the location will have an impact on the type of care that would be provided or expectations as well? We did hear some evidence that if it is, as it will be, initially located at TCH you might get more of that syphoning effect; whereas if it was in the community it might be a different sort of care which is going to be provided or a different approach. Do you think location will have an impact on that sort of thing?

Ms Cerasa: I believe it will. We know that people will often go to an emergency department because they have not been able to get a GP appointment and there will often be that very general need of care that is immediate and short term; whereas if the nurse-led clinics are established in areas where there are specific needs—and I am thinking more of low socioeconomic or greater long-term conditions or needs in community areas—I think it will initially determine the type of clientele that will go there.

It will be interesting to see, though, because I think that if people are aware of the type of care that they can have delivered in an area they may make the effort to go to those areas. I think that there is some potential that we may not have thought of yet about how people will be attracted to certain—

MS BRESNAN: Even it was just a general, community-located walk-in clinic, you

would probably be seeing more general people walking in as well. I thought it was interesting that you said that you thought that will happen. It might also broaden the scope of practice as well for the nurse practitioner that is located in—

Ms McLaughlin: And there are various different models. One is for a nurse practitioner who has an area of expertise. Let us say it is in respiratory illness. While a model allowed a nurse practitioner to be located in one GP practice in a particular suburb, there might not be the demand to access that expertise, but, if the model allowed that nurse practitioner to actually have clinics across the different suburbs on different days, people recognise the expertise and will go.

MS BRESNAN: The other thing I was going to ask you was: is it a stand-alone nurse clinic or are the nurse practitioners in GP practices? What is the model that you see as being of benefit? What is the best model to use?

Ms McLaughlin: I think there is a range of different models that respond to population health needs, that respond to the actual structure of the practice and the people seeking the care. For example, again, in the specialist expertise, there is an opportunity for a nurse practitioner whose area is in wound management to actually have a wound management clinic and therefore—

MS BRESNAN: And do that.

Ms McLaughlin: That is right. Or it might be reviews of diabetics. There is a range of specialities in which they could actually run speciality clinics. And then there is more the generalist model.

MS BRESNAN: And have you been providing that input to the government about the establishment of the clinics or has that been sought?

Ms McLaughlin: Yes.

Ms Cerasa: It does sound a bit like a sitting-on-the-fence answer, but I think there are horses for courses. There are different models that all work differently according to the population health. I can think of examples.

With a long clinical background in women's health and maternity services, I know that women would probably be attracted to a stand-alone where the focus is really on women's health issues. But then I could think of other examples where there are big populations or pockets of families that would probably like the general practice model where there is a nurse practitioner working with a GP; they are close to the schools. I think there are different models that all work in different environments. That is what I like about the diversity of it. If you can link it to population health planning and population health models, it makes a lot more sense.

MS PORTER: We believe there is a shortage of nurses in the ACT. Probably we are not alone in that. Do you think that having these different models that you are talking about is going to attract nurses back to the profession, from interstate or from overseas, to come and work here? I am particularly talking about the nurse practitioner role and the opportunity perhaps to increase the person's qualifications and have a different

experience. That is my first question.

My second question is: do you believe there is a nurse shortage and are there other ways to actually address that? Then my other question is: do you see a role for the nurse practitioner in the care of people with chronic illnesses?

Ms Cerasa: I will go first. The very short answer to your last question is absolutely yes. There is an absolute role for nurse practitioners in chronic conditions management, but I might come back to that.

On your first question about nurse shortage, the research is quite opposed to that. We have research that clearly shows that we have got enough numbers in the profession but we do not utilise them or put them into areas in proper and appropriate ways. Then there is other research that clearly demonstrates that we do have a shortage. Will opening up opportunities for nursing attract nurses back to the workforce? Yes, in some instances it will. I do not believe it will be a massive rush back to the profession because I think people leave for a raft of different reasons.

What I do think we have the opportunity to do—and somebody like RCNA is in a perfect position to promote this—is that we still have people seeking out education in universities to come and do nursing. A lot of them are gen Ys or new generation people, a new generation of thinking. I think we have to target that thinking and show that gen Ys do not actually have to leave nursing to have their second and third career choices. They can actually stay within nursing and look at a different career choice within the whole diverse range of nursing.

How do we develop the career, pathway and profession of nursing to better appeal to people to stay? Absolutely, with conviction, I believe that by opening up opportunities like nurse practitioner, advanced practice nurse, practice nurses, more roles and scope within primary health, within aged care, recognising the contribution that nurses make to the community's health and wellbeing, is what will absolutely attract nurses to be better regarded.

We cannot lose sight of the fact that 80 per cent of nurses currently work in acute health and that is part of the exhaustion that they feel. The most common reason they get cited for leaving acute health is that they are tired; it is complex care; it is difficult; it is exhausting; all those sorts of issues. That links back to the comment I made before about enrolled nurses and the next level of nursing.

If we actually look at the different roles and understand what we can do in the profession for the future of the community of Australia, I think that is where we have got a much greater opportunity. We allow nurses to do what they can do so well, according to their education and experience. We allow enrolled nurses to have a good standard of education so that they can do their scope of practice and deliver care and then we need to look at what that new, currently—however you wish to call them—unregulated workforce can do.

How do we look at that to support what we need for healthcare delivery? I think it has to be much broader than thinking that healthcare is only in hospitals. Sorry, I got on my soapbox about that. It is something I feel passionate about, obviously. Thank you

for hearing me out on that.

Ms McLaughlin: As Debra Cerasa has just said, you may not get a rush back attracting nurses to return to the workforce, but allowing nurses to work to their full scope of practice that they have been educationally prepared for and have the experience to work to will assist in retaining nurses in the workforce. There is a large exit a number of years after graduation. They have entered the workforce and they are actually quite disillusioned. They have been prepared to believe that they can use their skills and experience to a certain level but, in reality, in the workforce that is often being stifled. Therefore, if nurses are supported in working to their full scope of practice, it will actually assist in retaining them in the workforce.

MS PORTER: To clarify that, it is not only that they are not able to use their clinical skills so much, it is also that they are occupied in doing things which you would not consider to be clinical roles. Is that right?

Ms McLaughlin: Yes, there is that. Certainly if in general practice we took that as an example, a nurse might see the great scope of opportunity to work in general practice and the breadth of that general practice within the community and see all the positives in that yet be employed and find themselves working as a receptionist and doing clerical work.

MS PORTER: Or, in the hospital setting, doing other work?

Ms McLaughlin: That is right.

Ms Cerasa: Especially in hospitals, as you have just suggested, where they get caught up in lots of administrative and other aspects of business that take them away from being able to supervise the nursing care delivery and what is actually going on. That obviously moves away from the discussion we are having about public health; I am sorry to do that. I think it does link in.

MS PORTER: And it does affect our shortage. It does, overall, have an impact on nurses being available across the spectrum of care, does it not, if we are losing them out of any part of our system?

Ms Cerasa: Absolutely.

MS PORTER: Do you have any comments about nurse-led clinics specifically? Do you believe that will be an additional carrot for people to return to the workplace?

Ms Cerasa: It will be a carrot, but of course it all comes back to money. It depends on how that is funded and how nurses will be remunerated in a system like that. There is one strong voice of suggestion within the nursing profession that salaries out of Medicare for nurses in a primary healthcare setting could be very attractive and could also help set up different models of care that would support general practice clinics or support nurse-led facilities. So it does have a huge bearing on how people are attracted in that setting as well.

THE CHAIR: Can we get some clarification on the shortage? Is there a shortage of

nurses or do we have adequate nursing numbers? Are you aware of any figures in terms of how many graduates are being brought into the workforce each year in Canberra?

Ms Cerasa: I cannot give you that figure off the top of my head but we would be quite happy to go back and access that. We believe we could probably find that information for you very quickly. Sorry, I cannot pull it off the top of my head.

THE CHAIR: That is fine.

Ms Cerasa: If you are happy for us to contact the secretary, we could return that to you.

THE CHAIR: Yes, of course. By the way, from a general information point of view, if there are other areas of information that you think would be useful for us to consider, you do not have to appear each time; you can give us written submissions or additional information at any stage.

The second part of my question is really relating to—you touched upon it briefly, Ms McLaughlin—your statement that there are a lot of nurses who have left the profession. They also have skills that could be utilised if we have a shortage, but they had to be retrained, as I understand, as well; so there is that factor of how much retraining needs to be done if we have a shortage.

We are looking into the shortage of GPs but also looking at how other areas, including nurse practitioners, can alleviate the situation. I guess it is a multifaceted question that we are asking and we are trying to identify.

Ms Cerasa: I pick up a comment that you made before about using a specific example? In the age group of women that—and it is predominantly women—are still in nursing, they are predominantly the care givers for family life and generally take on the primary caring role within families. That is often a common reason why women will move in and out of their nursing careers. That does influence how and what they do.

Bearing in mind that we still think that roughly 80 per cent of nurses are working within acute health, and that involves 24/7 care, if we have got models of care where they can work in more family friendly hours, I think that is going to be a big attraction. Especially if we look at family friendly type models of care where people can job share or work part time or work in centres that are close to where their children are going to school et cetera, I think that does make a huge difference as to how it comes and goes.

Under the national registration scheme, when we have got a much more standardised benchmark for the need for retraining, refresher or re-entry, I think that we can reconsider how that is. In all the eight states and territories at the moment it is quite different how long you can stay away from the profession before you need to be retrained, refreshed or have to undertake re-entry. So that is quite a broad and complex question at the moment.

THE CHAIR: Is it different in each state and jurisdiction?

Ms Cerasa: Yes, it varies considerably. If I can take the opportunity to inform you of a document we would like to leave with you today called "Primary health care in Australia", this is a nursing and midwifery consensus view. There has been a working party of a number of significant key stakeholder groups that have contributed to this documentation. RCNA was on the working party, along with other stakeholders, and there is a lot of background information that answers some of the questions that you have raised. We would like to table that for you.

Ms McLaughlin: There is a range of models of care and examples of nurses in general practice, primary healthcare nurse practitioners, real models.

Ms Cerasa: One example that springs to mind that is in this book is that we know that there is an Indigenous nurse practitioner who specialises in renal health. We all know that closing the gap is a huge reform agenda at the moment for everyone, yet in the whole of Australia there is one Indigenous nurse practitioner and her specialty is renal. So the whole breadth of care for Indigenous health is not going to be covered by one nurse practitioner. That is one of the issues about how we attract more people to find that professional career path attractive and to encourage people into that area.

MS BRESNAN: We have had a couple of people give evidence about the UK nurse practitioner clinics. It has been used as an example. We have also heard different views about whether or not it has been successful. Is that something you have looked into at all, how it has operated and what the outcomes have been for people there that you are aware of?

Ms McLaughlin: It is a very different model. We often look to the NHS in the UK.

MS BRESNAN: And that is what I thought was new because it was a quite broader model which they have used.

Ms McLaughlin: That is right, and a different funding model in terms of what scope there is. We will often look to the UK, though, all the same, for the different models and the different practices. It is referred to in this document. That will give you a bit more background. Do you want us to provide you with more detail on—

MS BRESNAN: We have heard some people say it has not been very successful. Then we heard contradictory evidence that it has actually been good, anecdotally, and that people are much happier about the type of care they are getting. It is dealing with some of those others like triage so that people could be dealt with much quicker.

Ms McLaughlin: That is right, and it depends on the perspective that you take. If it is about quality of care and access to care, then there are a number of nurse practitioner models that provide great quality care and great access, particularly in aged care, and provide nursing expertise to the elderly in their homes, through general practice and in actual fact keeping them out of residential care. So there are a lot of very positive quality outcomes there. But then if you look at it from a financial funding perspective some will argue that it is costly. It depends on what perspective.

Ms Cerasa: I had the fortune to do a study tour of the UK in 2006 and looked at a whole range of different models. I would have to say that I generally saw it being more positive than not. The reasons why it would not generally be successful or seen as positive would be twofold. One would be the communication/education of health professionals and that local community. First of all, the community would not recognise the benefits of having the different models, and the health professionals within that community or region would not actually want that model to work. The second thing would always be funding, how it was actually funded.

Where it was successful and where it worked was in things like nurses seeing and treating in clinics where they actually had access and were able to resolve the overuse of emergency departments, the waiting times and all those sorts of things. Generally where I saw it being successful, it was extremely successful and people really liked the model.

But again it came back to people understanding what was being done and how it was communicated and educated to people. Communication to the community, education to health professionals, is the very blunt way of putting it and how it was funded, how people were able to access it. Of course, cost does come into it for people.

I think access is another key point. I am of the belief that, if you look at models and set them up properly, we can always make sure we deliver safe and quality systems. It is making sure we get it right from the beginning. So I think that that discussion should be inbred automatically into every conversation that we are having. It is about how we can make sure the right community gets the right care by the right type of people and have access to it.

THE CHAIR: Thank you very much for joining us and thank you for sending us the information and for the information that you are leaving with us. We appreciate that. If there is anything else that comes to mind that you think would help on the issues that we have been talking about, we would love to hear from you. Is there anything else that you wanted to say that you have not had the opportunity to either respond to or talk about?

Ms Cerasa: My other soapbox? I think that nurses are incredibly innovative by profession. I think if we can give the opportunity for nurses to contribute to the innovation and reform we can come up with some great ideas to contribute with our other health professional colleagues, especially in rural and remote settings. That is where the invention of great innovation really occurs and if we can give openness to that sort of opportunity I think—

THE CHAIR: You have an open invitation to submit any innovation that you want to put in but keep in mind that we are looking at the ACT jurisdiction as such. For anything that is relevant to our area, we would be very appreciative of any input. Thank you for joining us. There will be a full transcript given to you of what took place here today. Thank you.

The committee adjourned at 12.44 pm.